STATE TITLE V BLOCK GRANT NARRATIVE
STATE: LA
APPLICATION YEAR: 2006

I. GENERAL REQUIREMENTS

A. LETTER OF TRANSMITTAL

The Letter of Transmittal is to be provided as an attachment to this section.

B. FACE SHEET

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. ASSURANCES AND CERTIFICATIONS

Assurances and Certifications will be maintained on file in the MCH program's central office. Requests for copies of these documents may be obtained by sending a written request by fax to (504) 568-8162 or by mail to the following address:

MCH Block Grant Coordinator
Office of Public Health
Maternal and Child Health Section
325 Loyola Avenue, Room 612
New Orleans, LA 70112

D. TABLE OF CONTENTS

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

E. PUBLIC INPUT

Input from MCH stakeholders was facilitated by publishing the MCH priority needs and program activities in the May 2005 issue of the Louisiana Maternal and Child Health (MCH) Coalition News. The 210 members of the Coalition represent public and private hospitals, and obstetric and pediatric providers. The Priority Needs were distributed and the Needs Assessment process discussed at a meeting of the MCH Coalition Board on April 27th, 2005. Questions and comments from the Board pertained to Oral Health, local and regional input and involvement in the Needs Assessment process, and the Fetal and Infant Mortality Review (FIMR).

The Title V Block Grant application has become more accessible to Louisiana's citizens via Internet access. A summarized version of the application was posted to the MCH website on 5/24/05 (see attachment or www.oph.dhh.state.la.us/maternalchild/index.html). The summary document was reviewed by 30 CSHS Stakeholders, including Regional Coordinators and Outreach Specialists, from all 9 administrative regions of the state. The Stakeholders suggested that we address access to health care, dental care and transportation; provide ongoing education to CSHS families; address transition of CSHCN to adult services; emphasize mental health issues and ensure healthy pregnancies. Based upon Public Input from last year, the feedback form was changed so that it could be forwarded to MCH from the web site.

II. NEEDS ASSESSMENT

In application year 2006, the Needs Assessment must be provided as an attachment to this section.

III. STATE OVERVIEW

A. OVERVIEW

Louisiana is unique because of its history of a comprehensive publicly financed health care system to serve its large proportion of poor citizens. In the past, Louisiana has relied heavily on its regional, State-supported hospital system and large network of Maternal and Child Health (MCH) Block Grant and other federal and state funded public health clinics to directly provide preventive and primary health care for pregnant women, infants, children, and adolescents, as well as services for children with special health care needs, for its large medically indigent population. Maps 1, 2, and 3 of the attachment show existing Parish Health Units, State Charity Hospitals, and Federally Qualified Health Centers (FQHC), respectively. Additionally, the MCH Adolescent School Health Initiative began in the early 1990's and provides support for primary and preventive physical and mental health services in 54 state-funded, 1 federally-funded, and 1 private- foundation funded school-based health centers across the state.

Changes in the financing of health care services through the State system and the infrastructure of health department services have occurred in the past decade, which have affected the role of Title V in the health care system within the state. Since the Omnibus Reconciliation Act of 1990, Medicaid reimbursement for obstetric and pediatric care has increased, resulting in a growing participation of private physicians and hospitals in providing health care to Louisiana's low-income poor women and children. More recently, the State Medicaid Program has enacted several changes that have had a positive impact on financing health services for the low-income population. These include expansion of income eligibility for Medicaid through the State Child Health Insurance Program (LaCHIP), expanded income eligibility for pregnant women (LaMOMS), and statewide implementation of a primary care case management program for Medicaid recipients (Community Care). This has resulted in a decrease in the need for direct services through the public health units. Simultaneously, over the past several years, the state has experienced budget shortages that have impacted the services provided through the Department of Health and Hospitals. Ongoing budget shortages have resulted in hiring and spending freezes for all government agencies, restrictions on purchases, contracting, out of state travel, and cuts to contract expenditures. Since 2000, the Office of Public Health (OPH) has experienced a lay-off resulting in approximately a 10% reduction of the entire agency workforce and discontinued the staffing of 25 parish health units with the turnover of 18 of these units by contract agencies including primary care centers or hospitals. Since 2003, the management of Part C of the Individuals with Disabilities Education Act (IDEA) by the Children's Special Health Services (CSHS) program has been very successful with a 43% increase in children from birth to 3 years identified with developmental disabilities. The success of the program with a resulting increased enrollment and demand for services has lead to a significant increase in expenditures, which has put a strain on the entire Office of Public Health budget. This has resulted in budget constraints for all programs and a restructuring of the Part C program, called EarlySteps, emphasizing cost containment.

The reduction in staff has affected the MCH and CSHS Programs in several ways; one being a decrease in the number of MCH and CSHS visits. A comparison of visits in 2004 compared to 2003 shows a 7.8% reduction in child health visits and an 8.9% reduction in maternal health visits. However, the number of pregnant women and children receiving WIC and women receiving pregnancy testing services in parish health units increased from 129,031 to 137,144. The number of children served by CSHS continues to show gradual decline from 5,792 in 2002 to 5,360 in 2004. However, the number of clinic visits has remained stable, indicating that children with multiple special needs and more severe medical conditions are enrolled in the program. Enrollment in CSHS is also affected by income an eligibility criterion that has not changed in over 20 years. The CSHS program has completed 2 years of implementation of the EarlySteps program. This early intervention program has increased the staff and capacity of Title V in Louisiana in identifying and providing services to Children with Special Health Care Needs (CSHCN) and in establishing closer working relationships with other state agencies, parent advocacy groups and families.

Recent national events have impacted public health in the area of emergency preparedness for natural and man-made disasters with a primary focus on bio-terrorism. State and National sources of

funding have been used to build public health infrastructure. Approximately 50 new positions in the Office of Public Health have been added. The presence of these new staff in the areas of epidemiology, bio-terrorism coordinators, laboratory, and hospital nurse coordinators will have an overall impact of strengthening public health services. An example of how these efforts will complement Title V efforts is the use of a planned drill to test our capacity for mass immunizations as a focused community-based effort to provide childhood immunizations, which will impact our immunization rates.

Health Care Reform at the State and local level has been an issue addressed by the new Governor who took office in 2004. Utilizing information from Regional Summits with input from providers and citizens, the first Health Care Summit was held in March 2004. From this Summit has come initiatives to address the following areas: 1) Provide care to the uninsured which includes intensified outreach activities for LaCHIP, adult Medicaid outreach, looking at federal waiver opportunities, and obtaining a state planning grant to develop other options for providing access to affordable health insurance coverage; 2) Access to appropriate health care resources including transportation, improving access to Medicaid for pregnant women, and improving access to treatment services for addictive disorders; 3) Improving and restructuring long -term care, 4) Health education and awareness related to tobacco, obesity, and improving health in schools; 5) Improving administrative delivery of health care including the development of electronic Medicaid files and electronic prescribing and medical records; 6) Focus on performance outcomes using evidenced-based principles including the development of disease management initiatives and the development of decision support tools for Medicaid providers; 7) Reducing prescription drug costs and improving prescribing practices; and 8) Evaluation of the Medicaid Program. Regional Panels have been established to address these issues at the local as well as the State level. These Health Care Reform activities should have a significant long- term impact on the health care system in the state.

Nonetheless, even with improved financing of health services and changes in the public health delivery system, the need for MCH services continues. There remain areas where the Title V services continue to be a primary resource for prenatal care, preventive pediatric, and subspecialty pediatric services. Title V funds provide the wrap-around services for women and children receiving benefits from the Supplemental Food Program for Women, Infants, and Children (WIC) through 70 parish health units. These services include immunizations, prenatal and parenting education, case management, and referral for other health and social services. Although the numbers of women and children served through these clinics have decreased, services were provided to over 137,000 pregnant women and children, comprising a large percentage of the state's population of pregnant women and low income children under 5. Additionally, the MCH Program has continued to monitor the health status of Louisiana's mothers and children and has developed programs targeting those areas of the State with the greatest MCH needs. The savings in MCH funding resulting from the lay-off has been used to contract for the delivery of services by primary care centers, hospitals, medical schools and other community-based organizations in those areas. Thus, the Title V Agency continues to play the role of assuring access to needed services for the State MCH population.

1. Health Care Needs of the State's Population
Louisiana has ranked poorly on national comparisons related to health status and care. A 2005 national report published by Morgan Quitno Press titled "Health Care State Rankings 2005" ranked Louisiana 50th, worst in the nation in health indicators. The report is based on 21 factors that reflect access to health care providers, affordability of health care, and the generally health of the population. Examples of factors include births to teenage mothers, percent of population not covered by health insurance, death rate, and the sexually transmitted disease rate. Louisiana's ranking as the unhealthiest states stems from its high rate of uninsured, low rate of physical activity, high rate of diabetes, high infant mortality rate, high cancer death rate, and high rate of low birth weight babies. According to the 2004 National Kids Count Report, Louisiana ranks 49th of all states on indicators of child well-being. Although improvements occurred in 5 of 10 of the indicators, Louisiana ranked 49th for percent of low-birth weight babies and for percent of families headed by a single parent and 48th for infant mortality rate, percent of children in poverty, and percent of children living where no-parent has full-time, year-around employment. On the national CSHCN Survey (SLAITS), Louisiana was

found to have the 2nd highest percentage in the United States (U.S.) of CSHCN, suggesting that poor health indicators and general health of citizens results in a significantly higher than average percentage of children with special needs.

a. Louisiana population
According to the US Census from 2000 to 2003, the total population of Louisiana grew by 1.0% to an estimated 4,496,334 people. In terms of racial make up, Louisiana has two main racial groups, white 63.9% and black 32.5%, with 3.6% as other. This is vastly different from the racial make up of the U.S., where 75.1% of the population is white, 12.3% of the population is black, and 12.6% is other. (Figures 1, 2 and 3) The total number of women of childbearing age has decreased from 1,006,947 (22.5%) in 2000 to 983,257 (21.9%) in 2003. Teenagers 15-19 years and children 0-14 years comprised approximately 7.7% and 21.6% of Louisiana's population in 2003. The parish population estimates from 2000 to 2004 can be found in Table 1 of the attachment.

Although 72.6%, of the of the state's population lives in an urban setting, geographically Louisiana is a predominantly rural state. Only 27% of the 64 Parishes have at least 70% of their population classified as urban (2000 U.S. Census). Six of those parishes are located in the greater New Orleans metropolitan area. Most of the parishes in the Central and Northern parts of the State are rural.

In 2003, the Bureau of Economic Analysis reported Louisiana a having a per capita personal income of $26,038 compared to the national average $31,459. This shows an increase of 2.9% from 2002. Over the past 3 years, 2000 to 2003, Louisiana has had relatively no change in its median household income of $34,307. The unemployment rate, reported by the Louisiana Department of Labor, in March of 2005 was 5.3% compared with a national rate of 5.2%,
The overall poverty rate has not significantly changed in the past four years, 2000-2003. In 2003, Louisiana had an overall poverty rate of 17% or approximately 750,000 people. According to the U.S. Census Bureau, Louisiana had the 4th highest poverty rate in the U.S. for the period 2001-2002. Among the 50 states, Louisiana ranked 47th in child poverty. Only three states, West Virginia, Arkansas, and New Mexico had child poverty rates higher than Louisiana's rate of 25.5% in 2004. The 2004 national rate is 17.6% (United Health Foundation Rankings).

According to the 2000 Census, of the 64 Louisiana parishes, 19 have poverty rates greater than 25% with 3 with rates greater than 35%. Fifteen of these parishes are in the northern and central parts of the State. According to census data, 22.1% of families, with related children less than 18 years, live in poverty, as do 26.7% of families with related children under 5 years. According to the Census 2000, the Louisiana poverty rate for children aged 5 to 15 with disabilities was 35.3%, compared to 25.0% for those without disabilities. In the U.S., 25.4% of children with disabilities aged 5 to 15 lived in households with income below the poverty level, compared to 15.7% of children without disabilities.

Also impacting on the status of Louisiana's mothers and children have been changes in Louisiana's cash assistance program related to welfare reform such as limiting welfare benefits to two years in any five years; capping benefits at five years in a lifetime; and requiring twenty hours per week of work or work training, unless exempt. This has led to an 82% decrease in the number of monthly cash assistance recipients to 22,612 from July 1998 to March 2005 through the Families in Temporary Assistance Program (FITAP) operated by the State Department of Social Services (DSS). In March 2005, 17,448 or 77% of the 22,612 FITAP recipients in the state were children and 5,164 (23%) were adults. Thus far during State Fiscal Year 2004-2005, an average of 12,659 grants were paid each month with the average grant being $194.67. A survey done in 2003 by the Department of Social Services of 2000 families at or below 200% of Federal Poverty level found that more than half of respondents who completed FITAP were still in poverty. Almost 36% of those completing the 24-month program reported income at or below 50% of poverty, and another 32% reported income between 51-100% of poverty.

Low education levels are also a problem in Louisiana. Data from the 2000 census indicates that 32% of the State's population over age 25 years had only a 12th grade education with 9.3% having less than a 9th grade education.

b. MCH Health Status Indicators
Between 2000 and 2003, Louisiana experienced a 4.6% decline in the number of live births; most of the decrease (3.9%) in live births occurred between the years 2000 and 2001. In 2001, 2002 and 2003 Louisiana had 65,193, 64,755, and 64,689 births respectively. The infant mortality rate in Louisiana decreased from 10.2 in 2002 to 9.3 in 2003; this is the first decrease in Louisiana's infant mortality rate since 2000 and reverses the upward trend that had been seen since 2000. The black infant mortality rate of 13.8 is twice that of the rate of 6.4 for white infants (Figure 4). Disparities in the infant mortality rate are seen when looking at the nine different regions of the state (Figure 5). These disparities are reflective of differences in socioeconomic status and resource availability throughout the State with the poorer and more rural northern and central portions of Louisiana having worse indicators.

Very low (VLBW) and low birth weight (LBW) are major risk factors associated with infant mortality. There has been very little change in the VLBW and LBW rates in Louisiana. In 2003, the VLBW rate was 2.2% and the LBW rate was 10.7%. In the black population, 15% of all births were LBW compared to 7.7% in the white population. This racial disparity can also be seen in the VLBW rate (black=3.5%, white=1.2%). (Figure 6 and Figure 7) See Section II. E., the Outcome Measures narrative, for more information on infant mortality and racial disparities in infant mortality.

Prior to 2000, Louisiana experienced an overall decreasing trend in the child death rate. However, since 2000, the rate has increased from 30.8 deaths per 100,000 children to a rate of 34.8 deaths in 2002. Data for 2003 shows the increasing trend may be reversing with a child death rate of 26.5. Louisiana's child death rate remains higher than the 2002 national rate of 21.4 deaths per 100,000 children. The leading cause of deaths in children aged 1 to 14 was unintentional injury followed by congenital anomalies and homicide. Motor vehicle crash (MVC) deaths accounted for the largest number of unintentional injury deaths with fire and drowning the second and third leading causes. The 2004 Kids Count report ranked Louisiana 46th for violent deaths by accident, homicide, and suicide, for adolescents from 15 to 19 years of age. Violent deaths in both age groups disproportionately affect black children more than white children except for suicide.

According to the 2000 census, Louisiana had the fourth highest percentage of children aged 5 to 15 with a disability (7%) as compared to the national rate of 5.8%. In Census 2002, children aged 5 to 15 were considered to have a disability if one or more of the following long-lasting conditions was reported: sensory disability, physical disability, mental disability or self-care disability. Louisiana disability rates for males and females aged 5 to 15 were 8.8% and 5.1% respectively. In comparison, the disability rates for U.S. males were 7.2% and females 4.3% for the ages 5 to 15 population. In Louisiana, mental disability was reported for 5.5%; sensory, physical and self-care disabilities were reported for 1.3%, 1.3% and 1.1% of the 5 to 15 aged group respectively. Louisiana 5-15 age group's disability rates by race and ethnicity are: 6.6% for White, 7.3% for Black; 8.3% for the combined categories of Asian, American Indian/Alaska Native, Native Hawaiian/Other Pacific Islander, some other race alone and two or more races; and 6.4% for Hispanic or Latino.

Louisiana has an extremely high percentage of children with special health care needs as compared to other states. According to the SLAITS data, this state has the second highest percentage of CSHCN in the nation (15.9%). This is supported by statistics for the number of children under age 16 receiving federally administered SSI payments. Louisiana is the 11th highest state in the number of children receiving SSI while the 2004 U.S. Census indicates that Louisiana ranks 24th in population.

For those Louisiana families of CSHCN in the SLAITS survey, 85.5% indicated that their child received SSI, compared to the national survey response of 70.7%. The 2004 SSI data shows that 26,671 children under age 16 in Louisiana received SSI. This is an increase of 3,671 children from the 2001 Louisiana SSI count of 23,000 for this age group. Since persons with disabilities use significantly more medical services than those without disabilities, the high prevalence of disabilities among children in the state, indicates a tremendous need for health care services and resources for children with special health care needs

c. Access to health care
Louisiana has had one of the highest rates of uninsured population in the nation. According to the American Academy of Pediatrics, estimates of uninsured children in 2003, 15.4 % of Louisiana children through 18 years of age were uninsured, which placed Louisiana with the 5th highest rate of uninsured children. An estimated 77% of the remaining uninsured children were income eligible for Medicaid benefits.

Financial accessibility to health care for low income mothers and children has been through the state Medicaid Program. According to the 2002-2003 Fiscal Year Louisiana Medicaid Program Report, 990,544 Louisianans or 22% of Louisiana's population was eligible for Medicaid. Approximately 21% of Louisiana's population received Medicaid services. The percent of Medicaid recipients has increased by 4.2% since the 1999-2000 fiscal year. In State Fiscal Year 2002-2003, 722,430 or 69% of the Medicaid enrollees were under 21 years of age.

The State Medicaid Program has improved financial accessibility to health care for the MCH population through expansion of Medicaid eligibility for children as well as pregnant women. Improved access for children has largely been through the implementation of the State Child Health Insurance Program, LaCHIP. Louisiana's Child Health Insurance Program (LaCHIP) began on November 1, 1998, as a Medicaid expansion with a phase-in of income level eligibility to 200% of Federal Poverty Level (FPL) to age 19 on January 1, 2001. This program has been successful in increasing the numbers of children on Medicaid not just for the LaCHIP expansion but also for regular Medicaid. Since its inception, enrollment numbers have exceeded expectations with an increase of nearly 312,000 children from birth to 19 years of age enrolled in the Medicaid Program. As of March 2005 there were 669,575 Medicaid enrollees under age 19 through Medicaid/LaCHIP. Along with this, the percent of uninsured children in Louisiana has decreased from an estimated 22% in 1997 to 15.4% in 2003. Improved coverage for pregnant women began in January 2003 when income eligibility for pregnant women was increased from 133% to 200% of FPL.

Reasons for the success of LaCHIP include steps to streamline the eligibility process: 1) a simple, one page application form was created for both LaCHIP and Medicaid for children; 2) 12 month continuous eligibility was initiated; 3) the need for a face to face interview was removed and mail in applications are now accepted; and 4) a Central Processing Office was established to handle all child applications for Medicaid/LaCHIP. Medicaid has relied on regional outreach teams of existing Medicaid field staff to spearhead community-based outreach strategies statewide. Other steps taken since the beginning of the program include: 1) streamlining the LaCHIP/Medicaid recertification form, which is sent out to families after 12 months to re-apply for their children; 2) elimination of the three-month wait period after losing private health insurance before families can apply for LaCHIP; and 3) translation of the application form to Spanish and Vietnamese. With the implementation of the EarlySteps program, a new, shared application was developed for Medicaid, LaCHIP, the Office for Citizens with Developmental Disabilities, the CSHS Program and EarlySteps.

In comparison to the national average, Louisiana consistently ranks below other states on most of the National CSHCN Survey (SLAITS) indicators for access to care. Families report that their children and youth with special health care needs have less access to health care, require more time and financial resources than their peers in other states. Because of the high poverty rate in Louisiana and the fact that Louisiana has the second highest percentage of children with special health care needs of any state, financial access to comprehensive health care is a greater need in Louisiana than in most states. According to the CSHCN National Survey (SLAITS) data, only 51.9% of Louisiana CSHCN families said they had adequate public or private insurance to pay for the services they need, compared with 59.6% nationally. Forty-nine percent of CSHCN families have an income that is less than or equal to 200% of the federal poverty level. Twenty-two percent have Medicaid as their only source of insurance, 28.1% have more than one type of insurance, 41.5% have private insurance, and 8.1% are uninsured.

Pediatric primary and subspecialty care are concentrated in the major urban areas of the state. CSHS

Needs Assessment Data indicates that many of the pediatric sub-specialists were concentrated in the New Orleans area (27%) with many reporting that they traveled to more rural areas to provide care. Although the distribution of primary care for CSHCN was relatively equal by pediatricians and family practitioners across the state, only 52% of primary care physicians reported that they accepted Medicaid as compared to 69% of specialists. In addition, when further analyzed as to physicians offering access to CSHCN and CSHCN with Medicaid, data shows that in some rural regions of the state, access is restricted by half or more of the physicians not accepting patients with special needs and Medicaid. The most often reported barrier to care in focus groups of parents conducted in the CSHS Needs Assessment was lack of services or providers in an area.

d. Availability of health care
The majority of the state is designated as a medically underserved area or having underserved populations, by the Office of Primary Care and Rural Health. (Map 4). Availability of primary care practitioners poses a significant problem for delivery of health care in the state. As of March 2004, 56 or the State's 64 Parishes are designated a geographic or population group qualifying as a Health Care Professional Shortage Area (HPSA) (Maps 4, 5 and 6) by the Office of Primary Care and Rural Health.

Beginning in August 2001, the State Medicaid Program began a Region-by-Region expansion of its Community Care Program, which had been operating in 20 Parishes in the State. Community Care is a primary care case management program for Medicaid recipients. Through this Program, all Medicaid recipients are linked to a health care provider who serves as the client's primary care health provider as well as their primary care case manager. The primary care case manager is responsible for ensuring that all clients receive EPSDT services although the screenings may be done by another provider. However, maternity patients are exempted from this program and may select any provider. This process was completed in December 2003. This has resulted in an increase in the number of eligible clients who have received services.

The lack of availability of specialists in many areas of the state compounded with the fact that about one third do not take Medicaid means many CSHCN do not have access to specialty care at all. Because of the urban concentration of physicians in the state, access to Primary Care Physicians (PCP) and specialists in more rural areas of the state is extremely difficult for many CSHCN. Physicians who take CSHCN are concentrated around the two medical schools, children's hospitals, and leading medical institutions located in New Orleans and, to a lesser extent, Shreveport. A greater percent of specialists take Medicaid than PCP's. Of 631 specialists that take CSHCN, 409 or 65% take Medicaid. However, the lack of availability of specialists in many areas compounded with the fact that about one third do not take Medicaid means many CSHCN do not have access to specialty care at all.

Thus, budget shortfalls affecting the financing and therefore the system of health services in Louisiana present a challenge to the MCH Program for assuring the delivery of needed MCH services to the poor, predominantly rural, low education, minority MCH population in Louisiana and to our efforts to decrease the mortality and morbidity in this population. The MCH Program has responded to this by the development of initiatives to accommodate these changes.

3. Current OPH Priorities and Initiatives and Title V's Role
Louisiana, as one of the poorest and unhealthiest states in the nation, has the challenge of using its limited resources for the highest priority activities. Prevention services are under-funded as compared to other health care services. The Office of Public Health has defined its mission as follows:
- To promote health through education that emphasizes the importance of individual responsibility for health and wellness.
- To enforce regulations that protect the environment and to investigate health hazards in the community.
- To collect and distribute information vital to informed decision-making on matters related to individual, community, and environmental health.
- To provide leadership for the prevention and control of disease, injury, and disability in the state.

- To assure universal access to essential health services.

Operating within the context of the Office of Public Health and the changing health care environment, the Title V Program maintains its commitment to decreasing mortality and morbidity and assuring access to primary and preventive health care services for Louisiana's maternal and child health population including those with special health care needs.

For the MCH Program, the development of program initiatives has evolved into a process where data is collected, analyzed, and synthesized with knowledge on best practices to determine what would work best in Louisiana's unique environment. Program directors and epidemiologists review birth and death statistics, Pregnancy Risk Assessment Monitoring System (PRAMS) data, Infant and Child Death Review panels' recommendations, Medicaid E.P.S.D.T. reports, and other sources of information to determine the priority of competing factors impacting the health of pregnant women and children. Most data is analyzed by race and parish to determine racial or geographic disparities and trends in health status. Leading causes and associated factors of maternal, infant, and child death are reviewed and interventions are identified and implemented to address these problems. This year, the MCH Program has completed its five-year community- based assets/needs assessment, obtaining input from public health and community leaders from each region in the state. This has lead to determination of the priority needs for the State and the development of an operational plan to address each priority need.

CSHS implemented strategic planning in 2001 by establishing a Long Range Plan Advisory Committee with statewide stake holders including parents, private and public health care providers, elected officials, CSHS medical providers and local staff. The goal of the Long Range process was to improve the CSHS program by providing Medical Home and subspecialty clinical services by private providers in the community and monitoring, quality assurance and care coordination services to be provided by specialized OPH staff, where feasible. Critical to this process is the CSHS Needs Assessment completed in 2004 and used for the Block Grant and program planning. A statewide conference was held to analyze data for each region and make recommendations for changes in service delivery models. Work continues on recommendations for changes in the CSHS service delivery system for CSHCN to address areas identified in the Needs Assessment and through focus group and stakeholder participation. The provision of care coordination is one of the major goals to increase access to care and provide transition to adult services.

Thus, the Title V Program addresses each aspect of the OPH mission for the maternal and child population, including children with special health care needs, in the following ways:
- Health promotion is a major priority of the Title V Program, and includes public information and media campaigns on parenting, prenatal care, SIDS, and injury prevention. Public health staff provide health education and counseling to 137,000 pregnant women and children each year in individual patient counseling or group sessions.
- Some of the health hazards addressed by the Title V Program include lead poisoning, car safety and other injury prevention, and child care health and safety.
- The Title V Program shares vital statistics information widely as well as information from the Pregnancy Risk Assessment Monitoring System (PRAMS) which began in 1998. The Child Death Review process informs legislators and policymakers on the needs of children and families in the state.
- The Title V staff lead and participate in various task forces related to the health of women and children, including child abuse prevention, perinatal care, childcare health and safety, child death review, oral health, injury prevention, and birth defects. Title V works with professional and advocacy organizations to promote legislation and regulations to protect and promote the health of women and children.
- Through its system of parish health units, contract sites and school-based health centers, Title V is able to provide a statewide safety net of direct health services for women, children, and adolescents who are uninsured or have no access to other health care providers. With the largest number of poor children of any state, Title V resources continue to be dedicated to direct health care services. Children with special health care needs have access to a comprehensive, family-centered,

community-based network of pediatric specialists, including physicians, nurses, social workers, and other health care providers throughout the state through the CSHS clinics and community based services.
- "Every Child Deserves a Medical Home" is a priority of the CSHS program. CSHS Central Office and OPH Regional staff have participated in several regional presentations of the AAP program, "Every Child Deserves a Medical Home." This initiative included the formation of regional committees to address the issue of primary and preventive health care of CSHCN within the specified area of the state. Medical Home training has been incorporated into medical school training and as a pilot project funding care coordinators in three physician practices.

B. AGENCY CAPACITY

The State Title V Maternal and Child Health Program is housed in the Office of Public Health (OPH), Department of Health and Hospitals (DHH). The mission of DHH is "to protect and promote health and to ensure access to medical, preventive, and rehabilitative services for all citizens of the State of Louisiana. The Department fulfills its mission through direct provision of quality services, the development and stimulation of services of others, and the utilization of available resources in the most effective manner." The other agencies under the Department include the Office of Mental Health, Bureau of Health Services Financing (Medicaid), Office for Citizens with Developmental Disabilities, and the Office for Addictive Disorders. The Assistant Secretaries for each of these Offices meet weekly to collaborate and coordinate services for the citizens of Louisiana.

Personal health services and local public health functions are provided by 70 OPH parish health units distributed throughout the state, except in New Orleans and Plaquemines Parish, which have their own independent health departments (See Map 1 of attachment for map of parish health units). OPH has nine Regional Directors who supervise the health units, regional CSHS clinic sites, and regional health staff in their respective regions. The MCH Adolescent School Health Initiative provides funding and technical assistance to 51 contract school-based health centers, and 1 federally funded school-based health center. Infant Mortality Reduction Initiatives have been funded in each region, including a staff person to coordinate and direct Fetal-Infant Mortality Review, needs assessment and strategic planning for the maternal and child population.

Pregnant women and children, ages 0-21, who have no access to prenatal or preventive health care in the private sector, are served in MCH funded clinics whose services are linked with WIC, Family Planning, and Sexually Transmitted Disease services. Program directors at the state level meet regularly to coordinate these programs so the services will be "seamless" at the local level. MCH services are available in every parish in Louisiana. Orleans Parish operates an independent health department and receives support from the Title V Program. MCH provides funding to the New Orleans Health Department for an MCH medical director, a nurse consultant, and an MCH epidemiologist. MCH services are also provided through other medical and social services entities. Plaquemines Parish operates a clinic which provides EPSDT, immunization, and WIC services.

CSHS provides family-centered, community-based, coordinated care for children with special health care needs and their families, including rehabilitation services for children receiving SSI benefits, through its network of 175 pediatric subspecialty providers and facilities at the regional and local levels. Parents acting as family liaisons enhance the care coordination provided by the CSHS regional team and provide needed support.

CSHS has implemented a Long Range Plan to improve the system of services to CSHCN and their families in Louisiana. The goal of this process is to enhance community-based, private provider Medical Home and subspecialty clinical services. As CSHS strives to facilitate the development of systems of care for families, services are being merged with existing facilities or moved to local sites to complement the already existing service network established by the staff. CSHS has already begun the process of transitioning some clinical services to community private sub-specialists in the New

Orleans and Alexandria areas. A pilot is planned for one region of the state to convert staff to care coordination duties and transition children to private providers. CSHS has also been working with the AAP to work with local communities on capacity of primary health care services for CSHCN by facilitating Medical Home trainings statewide.

Enrollment in CSHS services have decreased 23% 2000. This is due to decreased numbers of families eligible for services based on static income criteria for the program. Some CSHS services have been reduced due to difficulty finding physicians to provide community-based services. The CSHS Long Range Plan Needs Assessment identified the capacity of private providers to serve CSHCN statewide and has led to the formation of a plan to address these issues.

The Hearing, Speech and Vision Program (HSV) also experienced a decline in the number of staff and patients. Private contractors, including the Lions Eye Foundation and other individual private providers, now provide vision screening services. Audiology services are provided by remaining staff and have been reduced by 50% since 2000. Presently, services are those for infants, toddlers and medically indigent children with hearing loss. Regional audiologists have performed regional needs assessments regarding available audiological services. Transition of these services will be incorporated into the CSHS plan.

Although the number of patients receiving prenatal and preventive child health services is decreasing, enabling and population-based services provided by contract agencies continue to increase. The State Title V Maternal and Child Health (MCH) Program has been able to shift significant resources from the funding of local parish health unit personnel to contract agencies, targeting services and areas of highest need as identified in the latest MCH Needs Assessments and other current maternal and child health data. This shift is due in part to the downsizing of the Office of Public Health parish health unit infrastructure and the new priority setting of parish health unit services to be offered to the public. In the past few years there has been a dramatic increase in Medicaid coverage of the maternal and child population in Louisiana through the Child Health Insurance Program, LaCHIP and LaMOMS (pregnant women coverage), expanding eligibility to 200% of the federal poverty guidelines. This health coverage and the statewide expansion of Community Care, Louisiana's Medicaid Managed Care system using a primary care case manager model has reduced the need for MCH to provide direct medical services in most areas of the state. The high priority services being delivered by the parish health units include WIC, Family Planning, Immunization, Tuberculosis Control, and Sexually Transmitted Diseases Programs. These Programs have greater difficulty finding community providers with whom to contract. MCH funded prenatal services are still provided in parishes without obstetric medical providers.

However, with a high poverty rate and its associated health problems, Louisiana's pregnant women and children continue to fall at the bottom of most studies that rank the states according to their population's health status. MCH is targeting areas of the state with the worst infant mortality problem by providing preventive and primary care services for pregnant women and infants. Contracts with health and social service agencies have been developed and services initiated to improve the health status of this population in cities including Shreveport, Alexandria, Baton Rouge, Lake Charles, Monroe, Lafayette and New Orleans, as well as Terrebonne, Jefferson and St. Tammany Parishes. Services include fetal-infant mortality review (FIMR) including a community advisory committee for needs assessment and strategic planning, prenatal clinical services, outreach, and case management including the evidenced based intervention, Nurse Family Partnership home visiting program. In some of these locations, the contract agency is the Louisiana State University Health Sciences Center (LSUHSC) that administers the services at the nine regional state operated hospitals in the major metropolitan areas of the state. The state hospitals and LSU have a long history of providing services to the low-income population.

In addition, MCH provides supplemental funding in the four Healthy Start Program areas in order to provide comprehensive services for this high-risk population. Six social worker case managers were added to the New Orleans Healthy Start Program last year and a FIMR coordinator has been hired for the newly funded Lafayette Healthy Start Program. MCH continues to fund a Nurse Family

Partnership team of nurses for the Baton Rouge Healthy Start Program and a team of outreach workers for the North Louisiana Healthy Start Program.

A contract with the Medical Center of Louisiana in New Orleans has been established to address the finding in the New Orleans' FIMR that 25% of the infant deaths reviewed had maternal substance abuse involved. The perinatal substance abuse prevention/case management project being implemented is based on Ira Chasnoff's model, which utilizes a comprehensive evidenced-based approach. A similar intervention was initiated this year in Monroe through an interagency collaboration between MCH, Office of Addictive Disorders, LSUHSC, and the Office of Mental Health. Louisiana has among the highest rate of low birth weight in the nation. PRAMS analysis showed that smoking and inadequate weight gain in pregnancy were the primary risk factors for low birth weight. MCH addresses gaps in smoking cessation services for perinatal populations through a contract with the Louisiana Public Health Institute, the recipient of the Louisiana Tobacco Tax Fund. This partnership has allowed expansion of the American Cancer Society's Make Yours a Fresh Start Family, a comprehensive smoking cessation program for perinatal populations. MCH contracts with an advertising agency to administer the Partners for Healthy Babies campaign. This is an outreach effort to link women with prenatal care and promote healthy behaviors. The program utilizes multiple partnerships, media messages, a toll-free information and referral hotline and other promotional activities to reach pregnant women and impact the determinants of low birth weight and infant mortality. This year, proper weight gain was one of the primary media messages.

Infant death data, PRAMS information, and FIMR studies show SIDS and prone infant sleeping position to be a problem in Louisiana. The MCH Program contracts with Tulane University School of Medicine, Pediatric Pulmonary Section, for the position of Sudden Infant Death Syndrome (SIDS) Medical Director. This partnership has allowed improved MCH Program state capacity to identify, counsel and follow-up families of SIDS infants and monitor the functioning of the overall program. The MCH Program staff includes a SIDS Program Coordinator who conducts state and community-based education on SIDS risk reduction, including a statewide media campaign.

To improve Louisiana's low breastfeeding rate, MCH has a contract with the Louisiana Maternal and Child Health Coalition to promote The Gift, a program to certify hospitals as breastfeeding-friendly facilities if they comply with a list of breastfeeding related policies and activities. Educational materials and incentives are included in this intervention.

MCH is targeting the leading causes of child morbidity and mortality by providing preventive and primary care services for children. Comprehensive preventive child health services, including physical examinations, laboratory and other screening procedures, immunizations, nutritional assessments and counseling, health education, and WIC services will continue to be provided in parish health units for children whose families are uninsured or are Medicaid eligible and have no access to private care. WIC services, immunizations, psychosocial risk assessment, and health and parenting education will continue to be provided in parish health units to patients referred by other health providers. MCH has a contract with Medicaid to conduct EPSDT screening in parish health units. Although private provider participation has decreased the number of children screened by MCH, there are still areas of the state where access is a problem and EPSDT services in parish health units continue to exist. MCH funds will continue to contract with St. Thomas Health Services, Inc. in New Orleans to provide support to community-based child health programs which provide pediatric primary care.

Through an interagency agreement with the Office of Community Services (Child Protection Agency), MCH utilizes public health nurses to assist child protection workers in investigating suspected cases of medical neglect, malnutrition and failure to thrive. Nurses assess the child in the clinic or home within 24 hours of request.

The state mandated Newborn Screening and Follow-up Program ensures that all newborns are screened before discharge from the hospital and again at the first medical visit, if the baby was initially screened before 48 hours old. The newborn screening battery consists of tests for the detection of Phenylketonuria (PKU), congenital hypothyroidism, hemoglobinopathies (sickle cell disease),

biotinidase deficiency, Maple Syrup Urine Disease, homocystinuria, medium chain AcylCoA dehydrogenace deficiency (MCADD), citrullinemia, argininosuccinic aciduria, and galactosemia. For infants with abnormal tests, Genetics Program staff assist the primary medical provider through the follow-up process to ensure timely and appropriate confirmatory testing and if determined to be diseased, treatment. The Genetics Program follows patients for specific time periods depending on their disorder. Contracts with three Louisiana medical schools will continue to provide laboratory testing and specialized clinical services for these patients.

MCH has initiated a new program entitled, Best Start, a therapeutic health/infant mental health intervention, utilizing a nurse, social worker and case manager to provide 8-10 week small group interventions during the prenatal, newborn and toddler periods Rapides, East Baton Rouge, Iberia, Ouachita, and Calcasieu parishes. Limited home visitation and ongoing treatment for mother-infant dyads in need of those services will be available on a limited basis.

MCH also funds nurse home visiting programs that follow the model for first-time mothers of low socio-economic status, entitled Nurse Family Partnership (NFP). Nurse visitors follow program guidelines that include regular visits to the family starting prior to twenty-eight weeks gestation until the child is 2 years of age. Nurses provide health education, referrals, case management and other support to women during and after their pregnancies, and their baby. Initiated in 1999 in four regions, the program now provides services in all regions of the state, including 18 parishes. Services are delivered in Region I (Jefferson Parish), Region II (Baton Rouge), Region III (Terrebonne and LaFourche parishes), Region IV (Iberia, St. Martin, Lafayette, and Vermilion parishes), Region V (Calcasieu, Beauregard and Allen parishes), Region VI (Rapides parish), Region VII (Caddo Parish), Region VIII (Franklin, Morehouse, Ouachita, and Richland Parishes), and Region IX (St. Tammany Parish).

MCH funds Louisiana's SAFE KIDS program, a comprehensive injury prevention program that organizes local chapters throughout the state, distributes newsletters and pamphlets, conducts special events, and participates in health fairs. Interventions address car, gun and fire safety, childproofing homes, bicycle helmet use, and sports injury prevention. To implement stronger prevention efforts, the MCH Program has established Regional MCH Injury Prevention Coordinators through contracts with social service agencies. These coordinators work to decrease unintentional injuries in children in each of the nine regions to establish and coordinate a region wide system of childhood injury prevention initiatives targeted at preventing injuries in children focusing on the most common causes of injuries in their areas. These Coordinators provide general child safety education and program development through coordinated efforts of MCH, EMS, Injury Prevention Programs and the local SAFE KIDS Coalitions and Chapters. They also provide support to local Child Death Review Panels.

MCH administers the Child Care Health Consultant Program by training, certifying, and facilitating the work of 170 health professionals who provide consultation and training on health and safety for childcare providers statewide. The Child Care Health Consultant Program trains and certifies consultants who provide the three hours of health and safety training required by Child Care Licensing in the Department of Social Services. Social and emotional health are being incorporated into this program's efforts.

MCH will continue to provide supplemental funding to the OPH Family Planning Program, which provides comprehensive medical, educational, nutritional, psychosocial and family planning services to adolescents and adults. MCH funds the Teen Advocacy Program in Baton Rouge, a community-based case management program for pregnant and parenting teens. A Medicaid waiver is being developed to continue coverage of family planning services for women past the current postpartum period and to include reproductive age women up to 200 percent of the Federal Poverty Level.

MCH funds the Louisiana Adolescent Suicide Prevention Task Force to develop and implement a Louisiana statewide plan on adolescent suicide prevention. MCH contracts with social service agencies to provide training on suicide prevention to school personnel statewide.

The Adolescent School Health Initiative Program will continue to collaborate with the Department of Education (DOE), the Office of Mental Health (OMH), the Office of Addictive Disorders (OAD) and the Excellence in Health and Education Project (EHEP) at Southeastern Louisiana University. Goals of the collaboration include providing state-of-the-art teaching and learning opportunities, advocating for the health and well-being of individuals in schools and communities, conducting research and evaluating services, and establishing a clearinghouse of resources for coordinated health and education.

CSHS provides rehabilitation services for CSHCN in nine clinic sites statewide, including services to children receiving SSI. CSHS provided services to 5,360 children in 17,088 clinic visits. Although the number of children enrolled has decreased, the number of visits has decreased at a slower rate, indicating the more complex and medically fragile patients remain on the program.

CSHS funds a specialty Dental Clinic for children with special health care needs in the New Orleans area. Services are provided by LSU School of Dentistry (LSUSD) and are specially designed to be readily accessible to this population, known to have barriers to accessing regular dental care. CSHS provides assistance through DHH/OPH Regional Offices for non-Medicaid eligible children to receive routine dental services through the private sector.

The CSHS Program provides parent support through all clinic team members including nurses, social workers, clerical staff, physicians, nutritionists, audiologists, other allied health staff and Parent Liaisons. Parent Liaisons are paid parents of CSHCN who attend clinics to give parent to parent support and organize and participate in support groups for families of CSHCN. In addition, the CSHS Parent Liaison staff work with the CSHS staff in identifying and incorporating culturally appropriate services to the diverse population served in CSHS clinics. Parent Liaison staff have provided community programs on cultural diversity and continue to work with families to identify better ways to improve services to families. All Parent Liaisons have undergone leadership training to increase their capacity to promote independence in families of CSHCN.

CSHS care coordination is family-centered and supportive of the child and caregiver needs through a plan that improves the quality of life by providing family support and enhancing family well-being. The inclusion of transition services into care coordination supports the self-determination and independence of adolescents with CSHCN.

As of July 1, 2003, DHH became the lead agency for the Part C/Early Intervention System, now called EarlySteps. This system transitioned from the Department of Education, which had been the lead agency since 1986. CSHS works with agencies statewide to build the system capacity to provide quality early intention services for infants and toddlers with developmental disabilities. DHH has established interagency agreements with the Department of Education/Special Populations, Office of Health Services Financing (Medicaid) and Office of Citizens with Developmental Disabilities to provide funding for Part C services. CSHS will also continue to work with other agencies to access additional funding, which will increase the capacity to serve infants and toddlers with developmental disabilities. In the first year of implementation, the number of children identified increased by 43% due to the longstanding emphasis on early identification within the Office of Public Health and the MCH and CSHS programs. A significant indicator of the impact of Part C being managed under a health agency is the dramatic increase in the number of children from birth to one year enrolled. In 2002 331 children under the age of one year were enrolled in Part C, in 2004 that number increased to 2,934, an 89% increase in 2 years. Budget issues with the tremendous increase in the number of children identified have triggered a significant restructuring of the program to make the best use of limited funding.

State legislation in 1999 established the Birth Defects Monitoring Network. Under the CSHS program, data collection started in 4 areas of the state in January 2005. Parents of children identified through the system will be offered information and referral to health care systems, as appropriate to their child's identified birth defect.

The Early Hearing Detection and Intervention (EHDI Program), within the Hearing, Speech and Vision Program, works closely will all birthing hospitals in the state to ensure hearing screening for all newborns. Newborn hearing screening results are reported on the electronic birth certificate. The EHDI program matches initial hospital hearing screening and follow-up results and is able to identify infants that have not had a screening test. Follow-up is provided for all infants with an abnormal newborn hearing screening, as well as infants that have not had a screening test. EHDI staff provided training and technical support to hospital personnel and also work with private providers to facilitate follow-up hearing evaluations.

CSHS funds a clinic at University Hospital in New Orleans to provide developmental services to children of mothers who are substance abusers. In addition to assessments, families are assisted with information, referral and follow-up to programs and agencies as determined by the needs of the child and family.

CSHS funds a program for specialized care of children with diabetes at Children's Hospital in New Orleans. This goal of this multidisciplinary program is to reduce emergency room visits, improve growth and development of the children, as well as decrease the average blood glucose level of the enrolled children.

The Louisiana Medical Home project under CSHS has participated in the National Medical Home Learning Collaborative. It currently funds a care coordinator in 3 pediatric practices in the state. In addition, training of medical school residents has been incorporated through the CSHS Medical Director who is on faculty at LSU Medical School.

The following State statutes are relevant to the Title V program:
1. LSA-R.S. 46:971-973 - Administration of MCH Services in State of Louisiana - Health Department Responsible
2. LSA-R.S. 17:2111-2112 - Vision and hearing screening - Health Department and Department of Education Responsible
3. LSA-R.S. 33:1563 - SIDS autopsy; reporting to Health Department Required
4. LSA-R.S. 40:1299 - Mandated Genetics - Newborn screening - Health Department Responsible
5. LSA-R.S. 40:1299.111-.120 - Children's Special Health Services - Health Department Responsible
6. LSA-R.S. 40:5 - State Board of Health authority to create MCH & CC Agency
7. LSA-R.S. 40:31.3 - Adolescent School Health - School Based Clinics - Health Department Responsible
8. LSA-R.S. 46:2261 - The Identification of Hearing Impairment in Infants Law - Health Department Responsible
9. LSA-R.S. 40:31.41-.48 -- The Births Defects Monitoring Network -- Health Department Responsible

C. ORGANIZATIONAL STRUCTURE

The Department of Health and Hospitals is one of twenty departments under the direct control of the Governor. The State Health Agency, the Office of Public Health is one of the five major agencies within the Department of Health and Hospitals (DHH). The State Medicaid Agency, Bureau of Health Services Financing, is also located in this Department as well as the Office of Mental Health, Office of Addictive Disorders and the Office for Citizens with Developmental Disabilities. The Title V programs, the Maternal and Child Health Program and Children's Special Health Services, are located in the Center for Preventive Health in the Office of Public Health, along with Family Planning, Nutrition, Genetics, Tuberculosis Control, Immunization, Sexually Transmitted Diseases and HIV/AIDS, and Adolescent and School Health Programs. The organizational charts in Figure 1 of the attachment illustrate the structure of the departments under the Governor, DHH, Office of Public Health, Center for Preventive Health, MCH, and CSHS.

The Children's Cabinet in the Office of the Governor provides a monthly forum for the Secretaries of

the child serving departments to meet and address the needs of children in Louisiana. The Children's Cabinet Advisory Board consists of the Assistant Secretaries of the agencies within the departments that serve children, as well as non-profit and advocacy organizations. This Board meets monthly and makes recommendations for policy, program development, and funding for child issues. MCH is represented on subcommittees of the Board. The Early Childhood Comprehensive Systems grant is being administered as a joint project of the Children's Cabinet and the MCH Program.

The Office of Public Health is organized into five centers, Center for Preventive Health; Center for Environmental Health; Center for Health Policy, Information, and Promotion; Center for Administrative and Technical Support; and Center for Community Health. The Center Directors, Program Directors, and Regional Directors meet regularly. The MCH and CHSCN Program and Medical Directors are the individuals primarily responsible for administering the programs funded by Title V. These staff report to the Director of the Center for Preventive Health, who in turn reports to the Assistant Secretary of OPH. The Directors of the Family Planning, Immunization, and Adolescent and School Health Programs are responsible for the proper administration of the Title V funds allocated to these programs and provide to the Title V Director annual reports and plans related to their particular performance measures.

MCH conducted an internal assessment of its organizational structure during last fiscal year. Fifteen lead MCH staff members attended a 4-day assessment and planning process, facilitated by a local consultant. Needs identified included new positions, staff recruiting, orientation, and retention, mentoring programs for new staff, communication and collaboration, contract development and monitoring, and physical space. A strategic plan was developed and subcommittees were formed to address each of these areas. As a result, a new orientation process was implemented for all new staff including a manual; a mentoring program was developed; new positions and vacancies were all filled; a contract manual and training module was presented to all MCH staff; a physical space plan was developed and most of the changes have been put in place. To address the communication/collaboration needs the MCH Program was re-structured by population and functional areas including Maternal Health, Child Health, Nurse Family Partnership, Epidemiology, Health Education, and Mental Health. The Team Leaders for Maternal Health, Child Health, Nurse Family Partnership, Epidemiology, and Mental Health meet with the MCH Director and assistant MCH Director every other week for a MCH Management Team meeting to foster collaboration among these programmatic and functional areas and to keep the MCH Director and each other informed. The Team Leader for Health Education meets with the health education team once a month and with the MCH Director once a month. The Maternal Health, Child Health, and Nurse Family Partnership Teams meet separately once a month and the Epidemiology Team meets weekly. MCH began a monthly series of meetings under the banner of "MCH Issues and Approaches." MCH staff and MCH stakeholders are invited to hear a focused presentation on an MCH topic, followed by a question and answer session. Over 200 people attended these meetings in the last year. An MCH Office Operations and Communications Committee meets bi-monthly to discuss any issues with the building or work environment that need addressing. The CSHS staff has undergone a rapid expansion with the addition of the Part C program, EarlySteps, and new staff dedicated to early interventions. CSHS staff meets monthly and individual work units, such as EarlySteps, Hearing Speech and Vision, and Birth Defects meet as needed. The CSHS administrative team of Program Manager, Medical Director, Nurse Consultant, Social Work Consultant and Parent Consultant meet frequently about policy issues and to approve special requests for services. The CSHS Management Team makes periodic visits to regional clinic sites to offer technical assistance and to gain input for program planning. CSHS and MCH collaborate through the MCH Epidemiology section where technical assistance is provided to the CSHS Epidemiologist and the Birth Defects Monitoring Network Coordinator.

The Nurse Family Partnership (NFP) team meets quarterly with the supervisors of the OPH and contract sites and conducts annual training with all NFP nurses. State MCH staff spends a great deal of time providing consultation and technical assistance with other public agencies, contract agencies, advisory boards and commissions.

The state is divided into nine administrative regions (see Map 1), with OPH Regional Directors in each

of the regions responsible for identifying and addressing the health needs of the population, assuring the quality of care, and providing monitoring and reporting of MCH services delivered through parish health units and contracts. State MCH Medical Directors and Nurse Consultants are responsible for the quality of the clinical services funded by MCH. Each contract funded by MCH has an MCH staff member responsible for ongoing performance monitoring. Program and contract monitoring consists of monthly review of fiscal information and performance indicators; and quarterly to annual on-site meetings with contract agencies to determine the quality of the service. Training and technical assistance is provided on a regular basis by MCH staff.

Health status information is shared with state, regional, and local public and private health and community leaders in an effort to engage stakeholders to partner with MCH to improve the maternal, infant, child, and adolescent morbidity and mortality rates. State MCH staff provides technical assistance and consultation to help local stakeholders in assessing needs and developing plans to address the needs. MCH provides funding to local entities or assists these groups in obtaining other sources of funding to address their maternal and child health needs. In order to strengthen MCH infrastructure in each of Louisiana's 9 regions, MCH has established regional Infant Mortality Reduction Initiatives, including contracts for the hiring of a coordinator for each region. The Initiative includes Fetal-Infant Mortality Review, needs assessment, strategic planning, and advocacy for the maternal and child population.

D. OTHER MCH CAPACITY

In addition to the Regional Administrator, each region has a Medical Director, Regional Nurse Consultant, Administrative Manager, Social Worker, Nutritionist, and Regional CSHS Staff. Although policy development and programmatic direction are provided by the State MCH Program staff, regional and local staff provide significant input. The State MCH/CSHS Program staff includes a Maternity Program Medical Director, Child Health Medical Director, MCH Program - Title V Director, CSHS Program Director and CSHS Medical Director. Staffing also includes a Statewide Maternity Nursing Consultant, Pediatric Nursing Consultant, CSHS Nursing Consultant, CSHS Social Work Consultant, CSHS Statewide Parent Coordinator, CSHS Statewide Part C Early Intervention Program Manager and Parent Consultant, Hearing, Speech, and Vision Program Director, Newborn Hearing Screening Statewide Parent Coordinator, MCH Assistant Administrator, MCH Nutritionist, SIDS Program Coordinator, Mental Health Coordinator, two CSHS accounting and contract monitoring staff, an Oral Health Director, a part-time Dental Consultant and Fluoridation Coordinator, three PRAMS staff, a Birth Defects Registry Coordinator, a CDC assignee MCH epidemiologist, MCH Health Education Coordinator, MCH Health Educator, Nurse Family Partnership (NFP) Director, NFP Nursing Consultant and NFP Program Manager, Child Death Review Nurse, Adolescent Health Initiative Coordinator, Folic Acid Coordinator, Adolescent Health Medical Director, four Adolescent and School Health staff, and ten clerical staff. Through MCH and CDC grants, The MCH Epidemiology Program also includes a CSHS epidemiologist, an Epidemiologist Coordinator for the Newborn Hearing Screening program, two Systems Development Initiative Epidemiologists, two CDC fellows, and an MCH Epidemiologist for the City of New Orleans Health Department.

In addition to program consultation, the CSHS Medical Director will work on special projects, such as Medical Home for CSHCN. One of the Medical Home priorities is to work with the Medical Home Learning Collaborative grant, which will enhance the capacity of Medical Home practices in the state. Medical Home training is being incorporated into the training of medical residents at state medical schools. A medical home project coordinator and social work consultant are also under contract to enhance primary core services through the Medical Home Project.

Early Steps, the Part C Early Intervention system, has 16 positions, including Program Manager. Seven of these positions are in Central Office and 9 positions are in the field, with one Regional Coordinator in each of the nine OPH regions. Some CSHS and EarlySteps staff work across programs to make the most efficient use of time and effective use of expertise. Parent Community

Outreach specialists are also employed in each region as well as a full time Parent Consultant for Early Steps.

The number of OPH Parish Health Unit staff resources (FTEs) funded by the MCH and CSHS Programs is approximately 77 and 45 respectively. As the number of staff decreases in the direct health care portions of the program, staff is being hired through contracts to initiate nurse home visiting programs and other initiatives across the state. Contracts are now in place to begin to build MCH services in areas of greatest need through contract agencies and institutions including medical schools, state operated and other hospitals, regional health and human service entities, and non-profit social service agencies.

Previously dedicated CSHS field staff had been integrated into the health units and cross-trained with other programs so that they can perform multiple duties. Additional health unit staff had been trained to assist in CSHS clinics. The CSHS program has provided two weeklong trainings and one clinical training for nurses to foster quality services for CSHCN.

Please refer to the attachment for brief biographies of the MCH Senior Level Management Team (Table 1). As of October 1, 2005, the current Child Health Medical Director, Dr. Jean Takenaka will be retiring. Dr. Gina Lagarde has been hired for this position as of July 1, 2005. Dr. Lagarde has 15 years of experience in pediatrics including one as the Director of MCH services for the New Orleans Health Department and a Masters in Business Administration. The double encumbrance period will allow a period of transitional training for Dr. Lagarde.

CSHS employs parents as Family Liaisons in all 9 Regional Offices. In addition to providing one to one family support and information, the Family Liaisons promote the issues critical to families with children with special needs in local communities and at a state level. The CSHS Statewide Parent Coordinator has been instrumental in providing input to policy and establishing links with other consumer organizations at the state and national level. In addition, a position has been established for a CSHS Statewide Parent Training Coordinator to provide consistent training for and communication among CSHS Parent Liaisons.

Nine Parent Community Outreach Specialists were added in 2003 to work in the EarlySteps Early Intervention System. These parents have gone through extensive training and will work closely with the EarlySteps OPH Regional Coordinator. A Statewide Parent Consultant has also been hired to coordinate the services of the Regional EarlySteps parents and to collaborate on policy development.

To enhance MCH capacity at the regional and urban areas in order to address priority needs, staff have been added through contract agencies. Contracts have been used because there is a strict limit on the number of state employees that can be hired in the DHH agencies. In order to address injury prevention, the leading cause of child death, Injury Prevention Coordinators have been hired in each of the nine regions of the state. These staff work under the direction of the Regional Medical Director. Likewise, to address areas of high infant mortality, Infant Mortality Reduction Initiative (IMRI) coordinators have been hired in all regions of the state. Those hired as coordinators are either obstetricians or nurses. The Regional Medical Directors play a lead role in collaboration with the IMRI coordinators to conduct Fetal-Infant Mortality Review, needs assessment, and strategic planning to address infant death, prenatal care, SIDS, and the interventions to address these problems. In the four Healthy Start projects, MCH has supplemented those programs with funding for prenatal care, or for enabling services such as outreach and case management, or infrastructure.

In the past year or more, there has been some transitioning of WIC services at the parish health unit away from the traditional use of nurses toward increased use of health educators. MCH is working with the OPH Regional Administrators to identify opportunities to utilize the resulting time available from the nurses who will no longer work in WIC services. The MCH services that nurses will devote their time to includes psycho-social risk assessment of pregnant women and infants and referral of those at risk to social workers, case managers, or other agencies such as the Office of Mental Health or Office of Addictive Disorders.

The MCH Management Team consists of the Maternity and Child Health Medical Directors and Nurse Coordinators, MCH Program Director, Assistant MCH Administrator, MCH Medical Epidemiologist, Mental Health Coordinator, and Nurse Family Partnership Director. Policy and program direction are developed in Management Team meetings held twice a month. The 2005 MCH Needs Assessment was led by the members of the Management Team and this group, along with the Needs Assessment Coordinator and a consultant, are using the Needs Assessment results to create a strategic plan for the next five years and an operational plan for the next 1-2 years.

E. STATE AGENCY COORDINATION

The Maternal and Child Health (MCH) Program has a long history of extensive coordination with public and private agencies and organizations serving pregnant women and children. MCH involvement with the Louisiana's Children's Cabinet Advisory Committee has facilitated the Cabinet's focus on prevention. Established by the legislature in 1998 as a policy office within the Office of the Governor, the Children's Cabinet has as its primary purpose the coordination of policy, planning, and budgeting that affects programs and services for children and their families and the elimination of duplication of services where appropriate. It is composed of the Secretaries of the Departments of Social Services (DSS), Health and Hospitals, Public Safety and Corrections, and Labor; the Superintendent of Education; the Commissioner of Administration; a member of the Louisiana Council of Juvenile and Family Court Judges, and a representative of the Office of the Governor, and a representative of the Children's Cabinet Advisory Board. The Advisory Board provides information and recommendations from the perspective of advocacy groups, service providers, and parents. Advisory Board members represent a wide variety of non-profit agencies, health and educational institutions, assistant secretaries from the Departments listed above, and juvenile court. The Children's Cabinet has recommended maternal and child health interventions among its top 5 priorities for funding, including expansion of the Nurse Family Partnership Program (NFP) (MCH's nurse home visiting program) and MCH administered adolescent school based health clinics. The Early Childhood Comprehensive System (ECCS) grant is administered as a joint venture between the Children's Cabinet and MCH/Office of Public Health (OPH). In the 2004 Legislative session H.C.R. No. 155 was passed asking for cooperation of State Agencies in the development of the strategic plan for the Early Comprehensive Systems Building Initiative. H.C.R. No. 155 "urges and request the following agencies, departments, and their corresponding offices work together in the ECCS strategic planning process: Office of Family Support and Office of Community Services within the DSS; OPH including the Part C - Early Steps Program, Office of Mental Health, Office of Citizens with Developmental Disabilities, Office of Addictive Disorders, and the Bureau of Health Services Financing (Medicaid) within the Department of Health and Hospitals; State Department of Education (DOE) including the Pre-K and Early Childhood Education Programs section; Board of Elementary and Secondary Education; Division of Administration; and Office of Youth Development within the Department of Public Safety and Corrections." The Resolution also called for quarterly reports to the Children's Cabinet and a competed Strategic Plan by June 30, 2005.

Early in the implementation of the NFP Program it became clear that the mental health needs of these first-time, poor, and often young, mothers were significant. MCH requested assistance from the state Office of Mental Health (OMH). The partnership resulted in the development of infant mental health consultation for these teams. A memorandum of agreement outlines how both agencies will coordinate services across the state. Following the successful implementation of this infant mental health intervention, the OMH received funding for an intervention to identify and mitigate the risks for young children ages 0-5 who are exposed to risk factors such as abuse, neglect, exposure to violence, parental mental illness, parental substance abuse, poverty, and developmental disabilities. The program promotes collaboration and partnership with all entities at the local (parish) level.

The MCH Program has supported an interagency agreement with the Child Protection Agency for the past 11 years to provide public health nursing assessments for children under investigation by the

Office of Community Services (OCS) for suspected failure to thrive, malnutrition, or other medical neglect.

The Fluoridation Program was created to promote, maintain, and monitor community water fluoridation to reduce the incidence of dental caries in all populations. The Fluoridation Program works with local government agencies to provide education and fund water systems that are initiating community water fluoridation. The Fluoridation Program works closely with the Louisiana Rural Water Association (LRWA) to educate water operators on the benefits and technical aspects of community water fluoridation. Members of the Fluoridation Advisory Board include a practicing dentist from each of the 9 Department of Health and Hospitals (DHH) regions, and representatives from the Maternal and Child Health Coalition, Louisiana Medical Society, Louisiana State University Health Sciences Center (LSU-HSC), Louisiana Rural Water Association, and a state licensed dental hygienist. At the 2004 Oral Health Summit, sponsored by the Oral Health Program, a wide range of attendees were present.

MCH has contracts with a New Orleans non-profit counseling agency to provide mental health services for children exposed to extreme violence including murder, families with a loss due to Sudden Infant Death Syndrome, and at-risk families with children age 0-5.

The Child Death Review Panel, established by the State Legislature in 1993, reviews all unexpected deaths in children under the age of 15. This panel includes representatives from MCH, OCS-Child Protection Agency, Coroners Association, Attorney General's Office, American Academy of Pediatrics, State Medical Society, Vital Registrar, State Police, Fire Marshall, the Legislature and the general public. The MCH Program currently staffs a full time position for the Child Death Review Panel.

The DSS, Child Care Assistance Program is a key partner with the MCH Program's Child Care Health Consultant (CCHC) initiative. The CCHC Program Director serves as a member of the ECCS Strategic Planning Committee, the Louisiana National Infant and Toddler Child Care Initiative, and the Bureau of Licensure's Task Force to write Standards for Quality Child Care. The CCHC Program Director also is chairperson of the CCHC Quality Improvement Committee and the Statewide Interagency Advisory Board for the CCHC Program.

The Medicaid Agency, the Bureau of Health Service Financing, and MCH coordinate in program development and data sharing. MCH is a Medicaid provider of EPSDT services, prenatal care, and case management. Local parish health units (PHU) determine eligibility for pregnant women to become Presumptively Eligible for Medicaid and assist pregnant women and children with the eligibility process for Medicaid and CHIP. PHUs continue to be the largest source of applications for Medicaid/CHIP. In large PHUs, Medicaid has out-stationed an eligibility worker to expedite applications for pregnant women, reducing the waiting time from as much as 45 days to 48 hours. MCH advocated for and assisted Medicaid in preparing the data and information to convince policy makers to expand Medicaid coverage for pregnant women from 133% of the federal poverty guidelines to 200% in January 2003. Starting in November 2003, this includes dental coverage for pregnant women with periodontal disease.

MCH has a memorandum of agreement with the state Office of Addictive Disorders (OAD) to provide pregnancy testing and prenatal care referral for women served by OAD. MCH provides the test kits, training, and access to services of the PHU for pregnant women. Other collaboration includes assigning OAD substance abuse counselors to work with perinatal substance abuse programs in New Orleans and in Monroe.

Local PHU staff funded by MCH provides pregnancy testing, prenatal care and education, preventive child health services, presumptive eligibility and home visiting services statewide. WIC services are provided at the same time patients receive MCH prenatal and EPSDT services. PHU WIC patients who receive prenatal or child health care from private providers, receive health counseling, education, and referral from MCH funded staff. The state Title X Family Planning Program receives funding from

MCH. Family Planning services are provided in PHUs and contract agencies statewide and are linked with prenatal services funded by MCH. Program directors of MCH, Family Planning, WIC, and other programs coordinate services and planning during regular OPH staff meetings.

New Orleans has an independent health department and MCH funds maternal and child health services. MCH provides funding for the MCH Medical Director, MCH Nurse Consultant and an MCH Epidemiologist for the New Orleans Health Department. Six social workers were funded by MCH to expand the New Orleans Healthy Start project area. MCH funds a large prenatal clinic in a low-income neighborhood with Louisiana State University (LSU) Medical School providing the clinical services and the City of New Orleans providing the facility. MCH provides funding for prenatal care and/or pediatric services in primary care centers in Orleans, St. Charles, and Caddo parishes. Prenatal clinics, outreach, case management, and home visiting services are funded by MCH in the four Healthy Start grant project areas.

A key provider of MCH services across the state is LSU-HSC. LSU-HSC administers the services of the 9 state operated hospital located in each region of the state. MCH contracts with LSU-HSC in 4 of the 9 regions to provide prenatal care, nurse home visiting, case management, pediatric services, Fetal-Infant Mortality Review (FIMR), needs assessment and strategic planning. These activities comprise the Infant Mortality Reduction Initiative (IMRI) functions. In the remaining regions, the IMRI is coordinated by public and private hospitals, universities and social service entities. LSU Dental School collaborates with MCH to provide the Oral Health Director, Dental Consultant, and Fluoridation Coordinator to administer the state Oral Health Program.

Louisiana is one of five states participating in the Action Learning Lab (ALL), Tobacco Prevention and Cessation for Women of Reproductive Age. MCH led the efforts for this collaboration along with the American College of Obstetricians and Gynecologists (ACOG) Louisiana, Planned Parenthood, Louisiana Public Health Institute (LPHI) and Medicaid. Information on smoking cessation and provider trainings was disseminated to over 200 ACOG providers. MCH contracts with LPHI to provide the evidence-based American Cancer Society's Make Yours A Fresh Start Family, a smoking cessation program for pregnant women. MCH participates in the State Infant Mortality (SIM) Collaborative. Five states are working to develop Tool Kits to address programs, policies, best practices and evidence based programs impacting infant mortality. The MCH Maternity Medical Director and Nurse Consultant collaborate with other groups on perinatal issues: Infectious Diseases, STD, HIV, Office of Addictive Disorders, OMH, School Based Health, American Cancer Society, March of Dimes, and faith-based initiatives.

MCH collaborates with the Louisiana Folic Acid Council to promote folic acid consumption to reduce the incidence of neural tube defects. The Council works with representatives from the March of Dimes, LSU-HSC, the Louisiana MCH Coalition, LSU Agricultural Center, KidMed, Shriner's Hospitals for Children, Southern University and the University of New Orleans in promoting folic acid consumption to women. MCH is represented on the Louisiana Council on Obesity Prevention and Management. The council's purpose is to study the issues relative to obesity in Louisiana, collect data on the subject, and develop recommendations for improving awareness regarding the health risks associated with obesity and suggesting modalities for treatment. Its membership includes DHH, the State DOE, the Pennington Biomedical Research Center and others.

Tulane University Health Sciences Center (TUHSC) collaborates with MCH to provide essential services. The SIDS Medical Director is a Pediatric Pulmonary Specialist in the TUHSC Department of Pediatrics. Evaluation, biostatistics, and health communication expertise is provided through contracts with the TUHSC School of Public Health and Tropical Medicine. Each semester at least 5 MPH students conduct their required internship in the MCH Program.

The MCH Director and the Maternity Program Medical Director serve on the State Commission on Perinatal Care and Infant Mortality, standardizing the framework for regionalization of perinatal services by determining the level of hospital services provided. These standards are used by the Hospital Licensing Section and for Medicaid reimbursement. The MCH epidemiologists present

findings from birth and infant death and PRAMS data analysis at the Commission meetings to inform policy decisions.

The Adolescent School Health Initiative Program regularly convenes the Intergovernmental Coordinating Council to assist in implementation, oversight, and funding assistance for school-based health centers. The Council is composed of representatives from the State DOE, OMH, OAD, the Excellence in Health and Education Project (EHEP) at Southeastern Louisiana University, the state Medicaid Office, DSS and other health service entities.

Childrens Special Health Services (CSHS) is uniting with established partner organizations, private providers, parents and other stakeholders to implement a Long Range Plan to providing services for children with special health care needs (CSHCN) statewide and also to strategize for the future direction of the CSHS Program. Agencies and organizations that participated in this collaboration in 2001 and continue to participate include Children's Hospital, Tulane Hospital for Children, Shriner's Hospital, statewide Families Helping Families members, private physicians, OPH, Medical Center of Louisiana at New Orleans, state congressional staff, as well as parents stakeholders. As a result of this collaboration and teamwork, CSHS contracted with LSU-HSC in 2003 to conduct a Statewide Needs Assessment that will describe the current access to health and related systems of care for the provision of comprehensive and coordinated care of children birth through 21 years in Louisiana. CSHS has begun regional planning with local stakeholders, medical representatives, OPH staff, other agencies and parents to formulate plans for future CSHS services, as well services for all CSHCN in the community.

CSHS is also working in partnership with many agencies and organizations to address the need for primary health care services for all CSHCN in Louisiana. Since 2000, CSHS has collaborated with the Louisiana Chapter of the American Academy of Pediatrics to provide "Every Child Deserves a Medical Home" trainings. CSHS has taken leadership in planning meetings with local agencies and organizations including local hospitals, private providers, Medicaid, Social Security, Vocational Rehabilitation, State DOE, LSU Medical School, Tulane University Medical School and School of Public Health, ChildNet, Office of Citizens with Developmental Disabilities, Agenda for Children, Families Helping Families, Family Voices, City of New Orleans Health Department, health care organizations and parents. The OPH has directed each of the 9 OPH regions to plan and implement a strategy to address the issue of adequacy of primary care providers to serve CSHCN statewide. CSHS will continue to work with each of the remaining regions of the state as they plan for Medical Home.

CSHS is currently managing the EarlySteps program under Part C of Individuals with Disabilities Education Act. CSHS officially assumed responsibility for administering this early intervention program on July 1, 2003. Multiple agencies and stakeholders are represented on the State Interagency Coordinating Council, the entity that provides advice and assistance to EarlySteps. CSHS continues to partner with these agencies and individuals, focusing on Personnel Preparation, Service Coordination, Finance and Public Relations for the EarlySteps Program.

CSHS and EarlySteps are also collaborating to develop interagency agreements with several agencies. Negotiations are in progress with the State DOE, Office of Health Services Financing, Office of Citizens with Developmental Disabilities and Bureau of Health Services Financing (Medicaid) to ensure a coordinated system of early intervention services.

CSHS works with WIC to establish procedures of identifying children eligible for Part C services and expediting referrals to the Part C Systems Point of Entry locations. CSHS plans to continue this ongoing partnership to assist in the identification of children and in providing services for CSHCN.

In addition, CSHS has been working in partnership with LSU School of Medicine to provide services for children of mothers who are substance abusers. CSHS funding is supporting the services of a Developmental Specialist who provides clinical services for identified children in clinics at University Hospital in New Orleans. In addition to assessments, this clinic provides information, referrals and

follow-up to programs and agencies as determined by the needs of the child and family.

CSHS has also pooled resources with Children's Hospital to establish a model program dedicated to the specialized care of children with diabetes in Louisiana, with a focus on prevention of acute and chronic complications. This program provides the team services of a pediatric diabetologist, pediatric diabetes nurse educator, pediatric nutritionist, pediatric psychologist, exercise trainer and visiting pediatric diabetes liaison nurse. The goal of this program is to reduce emergency room visits, improve growth and development of the children, as well as decrease the average blood glucose level of the enrolled children.

CSHS, LSU Dental School and Children's Hospital have jointly provided funding for the Special Children's Dental Clinic at Children's Hospital. LSU Dental School staffs the clinic with pediatric dentists, dental students and dental support staff. CSHS provides funding for clinical services. This clinic services CSHCN from the 9 statewide CSHS clinics, as well as private clients.

CSHS is implementing the Birth Defects Monitoring Network. This name emphasizes partnering with other projects and agencies to ensure success of the program. The Advisory Board consists of 9 members including representatives from the Louisiana State Medical Society, Ochsner Foundation Medical Center, Tulane University Medical Center, LSU-HSC, March of Dimes, MCH Coalition, OPH, a parent representative and a consumer representative. At present, Louisiana has hired surveillance staff for the program in a partnership with LPHI. The Hearing, Speech and Vision Program (HSV) within CSHS works closely with all birthing hospitals in the state to ensure hearing screening for all newborns. CSHS also collaborates with private audiologists and the medical community for follow-up evaluations or for families with lack of insurance or no access to local community services. The State Advisory Council for Newborn Hearing Screening is appointed by the Governor and includes 14 stakeholders and advises the program on the EHDI system in the state.

CSHS has ongoing meetings with Medicaid and Community Care to address issues related to provision of services for CSHCN. CSHS also is negotiating an interagency agreement with the Bureau of Health Services Financing (Medicaid) to ensure a coordinated system of early intervention services for CSHCN.

The CSHS Program Manager participates in the State Planning Council for Developmental Disabilities in Louisiana. Other members of this council include the Advocacy Center, LSU-HSC Center for Excellence in Developmental Disabilities, self advocates, parents, State DOE, OMH, Office for Citizens with Developmental Disabilities, Louisiana Rehabilitation Institute, Governor's Office on Disability Affairs, Governor's Office on Elderly Affairs and others. This ongoing collaboration addresses issues related to all aspects of life for persons with disabilities.

F. HEALTH SYSTEMS CAPACITY INDICATORS

The following is a discussion of the data collection process, limitations and proposed actions for Health Systems Capacity Indicators.

17. 1. The rate of children hospitalized for asthma (ICD-9 Codes: 493.0-493.9) per 10,000 children less than five years of age.

This data is collected from the Louisiana Inpatient Hospital Discharge Database (LAHIDD), which is administered by the State Center for Health Statistics (CHS). FFY 2003 counts for this indicator were similar to FFY 2002, however, somewhat different from those provided for previous years. This is a result of missing ICD-9 values being included in the previous asthma definition. A slight decrease from 2002 (rate of 61.4) to 2003 (rate of 57.6) was noted and may be a reflection of Community Care primary care case management system implementation by Medicaid in 2003 and Medicaid Quality Improvement Initiatives related to asthma.

Data sent by hospitals licensed in Louisiana to LAHIDD are for the most part, a natural by-product of

hospital billing activity and are already widely available in a reasonably standard electronic format. Data is received on a quarterly basis from the hospitals. In the calendar year 2003, 61.08% of licensed hospitals (total hospitals = 203) in Louisiana submitted data to LAHIDD. A number of barriers hinder timely availability of the data for grant purposes, and result in information required being at least one year behind schedule. Data for 2004 is currently in the process of being received from hospitals to LAHIDD.

17. 2. The percent Medicaid enrollees whose age is less than one year during the reporting year, who received at least one initial periodic screen.

This data is collected from Louisiana's Bureau of Health Services Financing (BHSF) office. The indicator is an established measure and is readily available on a timely basis at the end of each federal fiscal year. While some states have separate Medicaid and Children's Health Insurance Programs, Louisiana's Children's Health Insurance Program (LaCHIP) is administered from within the Medicaid office. As a result the counts provided for this indicator include Medicaid enrollees in LaCHIP. The count is based on those children receiving Early Periodic Screening and Diagnostic Treatment (EPSDT) and is therefore an undercount because it does not include Medicaid enrollees who received services other than EPSDT.

17. 3. The percent State Children's Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.

This data is also collected from Louisiana's Medicaid Office. Given that this measure is not established within the Medicaid office, information for this indicator is received on a less timely basis each federal fiscal year. The process involves making a special run of the software used to generate counts.

17. 4. The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.

This data is collected from the State's Vital Records Registry from the Certificate of Live Birth, and is prepared and received from the Center for Health Statistics. Data is usually received on a timely basis, given that the CHS usually closes out the birth data file in the late spring to early summer. Due to recent changes in procedures and regulations regarding acquisition of vital event data within the CHS, it has been taking slightly longer to get the data for analysis, in this case the 2003 data. Vital Statistics data is based on the regular calendar year. See National Performance Measure 18 for more information regarding prenatal care.

18. 5. Comparison of health system capacity indicators for Medicaid, non-Medicaid and all MCH populations in the State

This data involves matching data from the CHS, live birth and infant death data, and Medicaid eligibility data. Variables used in the matching process include: mother's last name, date of birth, race and social security number.

Since 2002, the Office of Financial Research and Planning (OFRP) within DHH has obtained access to Data Warehouse data for eligibility and claims files. Extensive MCH collaboration with the Office of Financial Research & Planning has strengthened alliances for Medicaid linkage efforts. Currently, for linkages utilizing the most recent birth and death data (2003), the Division of Health Economics and the Bureau of Health Services Finance within Medicaid developed a 5 -year memorandum of understanding (MOU) for inter-agency data sharing. Identical linkage methodology for 2002 data was conducted with 2003 for comparison. In addition to deterministic linkage methodology, MCH and Financial Research and Planning staff are building knowledge to conduct probabilistic linkages.

18. 6. The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to1), children, Medicaid, and pregnant women

This data is collected from the Medicaid office. The indicator is established within that office and is therefore readily available at the end of each federal fiscal year.

18.6. The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, SCHIP, and pregnant women

This data is collected from the Medicaid office. The indicator is established within that office and is therefore readily available at the end of each federal fiscal year.

17.7 The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.

This data is obtained from the Louisiana Bureau of Health Services Financing (BHSF) on the HCFA 416 form. The data collected is broken down into this age group so this information is readily available through the Medicaid office at the end of each federal fiscal year.

Forty-one percent of EPSDT Medicaid eligible children aged 6 through 9 years received at least one dental service during the year. Even though utilization of dental health services in Louisiana is comparable to other states in the south central region (including AR, LA, TX, OK), there remains a large group of eligible children aged 6 through 9 years who are not receiving dental services in Louisiana.

Providing access to oral health care in regions where there are few or no dental providers has been a challenge. Of the nearly 2,500 dentists holding licenses in Louisiana only 985 were enrolled as Medicaid providers as of April 30, 2005. Of this total, only 637 had provided at least a single dental service to a Medicaid recipient in the 10 months of the fiscal year. Of those, 431 had delivered a range of services averaging at least $1,000 monthly in the first 9 months of the current fiscal year.

Utilization of oral health care services is diminished in regions where transportation is a problem, and where awareness, and education on the importance of oral health care is not emphasized. These finding suggests that there is a dental workforce shortage to treat Medicaid-eligible children, a disincentive to treat this population because reimbursement rates are low, and a lack of support to families through the Medicaid services to ensure that oral health issues are being addressed.

Dental professionals and concerned citizen groups are working with the legislature to appropriate additional funds for the Medicaid EPSDT dental program in the upcoming fiscal year budget. An increase, if granted, would be used to increase the reimbursement rates, hopefully attracting additional providers and insuring against the loss of currently enrolled providers.

In order to address the dental workforce shortage, a committee comprised of representatives from the Louisiana Dental Association (LDA), the Louisiana Dental Hygienists Association, and the Louisiana State Board of Dentistry is meeting to propose legislation for the next legislative session to expand the practice setting in which dental hygienists may provide preventive services for patients under general supervision. This was one of the major recommendations of the 2004 Oral Health Summit and, if successful, would increase the abilities of dental hygienists to deliver preventive services in rural/underserved areas of the state.

17.8. The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from State Children with Special Health Care Needs (CSHCN)

This data is collected from the Social Security Administration and the Medicaid office. The Social Security Administration provides the denominator for this indicator, the number of children less than 16 years old receiving SSI benefits in Louisiana as of December of the calendar year. The numerator

was collected from the Medicaid office, and represents the number of SSI recipients 0-16 who received any service from Office of Public Health clinics. This includes services that are not specifically rehabilitation services, such as WIC and immunizations. As of SFY 2000, Medicaid moved into a new swipe card system. The new Medicaid numbers do not code for SSI recipients as before, so the previous count that was conducted on CSHS patients not receiving rehabilitative services became impossible. For SFY 2000, an attempt to collect data on SSI status by phone from the CSHS regional clinics resulted in what presents as a significant decrease of SSI beneficiaries in that year and is probably an under representation. SSI services continue to be provided as usual and provisions are to being made to re-identify this population.

19. 9 A. General MCH Data Capacity: The ability of the state to assure MCH Program access to policy and program relevant information.

The State System Development Initiative (SSDI) grant enhances the data capacity of Louisiana's MCH and CSHCN programs to assure access to data that is pivotal to policy and programmatic decisions. The SSDI coordinator and data manager collaborate with the Center for Health Statistics (CHS), Financial Research and Planning, WIC, and the Genetics Department, to facilitate the linkage of birth and infant death data with Medicaid, WIC, and the newborn screening program data. To date, successful linkage has been made between the vital event data and Medicaid data allowing performance of analyses that take into account the Medicaid eligibility of the population and specifically address HSCI-05.

An attempt was made to link the 2001-2002 WIC database in PASPORT format to the birth files. The WIC data contained a very high level of missing values for social security number (SSN) required with use of the deterministic record linkage method, resulting in a match for only about 20% of the data. Analyses utilizing linked 2001-2002 birth-WIC file identifying health outcomes and disparities between mothers and babies receiving WIC benefits and those not receiving WIC benefits has not done. MCH is working to improve the quality of incoming WIC data for further attempts at linking the databases. The WIC PASPORT database is in the process of being replaced by the WIC Public Health Automated Management Enabler (PHAME) and Master Patient Index (MPI) systems. The new PHAME system will be operational statewide by October 2005. The MPI correlates and cross-references computerized client demographics records from Vital Records and WIC databases while matching key identifiers. As a result of the WIC database undergoing a major migration from PASPORT to PHAME system, linkage efforts are anticipated in August 2005 after completing database migration. SSDI data manager and coordinator will be able access WIC data and assist WIC registry staff in performing the linkage of vital records with WIC database in PHAME system

A trial linkage between the newborn screening file of all infants screened for the period of October 2003 through December 2003 and birth files for the same time period was completed in April 2004. Birth records determined a high rate of matching for records from a private hospital laboratory, but a low rate for the records from the two other laboratories as the mother's social security number was not captured on those files. Therefore, it was decided to suspend further trial match activities while infrastructure improvements could be addressed. This included the installation of an upgraded laboratory data management system planned for State Fiscal Year 2005. However, the installation of this system will be completed in December 2005. This new system will allow for greater flexibility in the compiling of files which means social security number would be included. Also, further standardization of the data fields on the newborn screening record will occur through enforcement of the amended newborn screening rule which will make some data fields required that had been optional. Promulgation of the rule is anticipated by October 2005; at which time the pilot for matching newborn screening and birth records will be reactivated. No analyses utilizing linked birth-newborn screening file, to identify newborn populations who do not appear in newborn screening file, has been done.

Additional efforts to enhance the data capacity of MCH and CSHCN involve the institution or receipt of information from data registries and from surveys. Direct access to 2003 LAHIDD data has been granted and will be available by September 2005. Currently, descriptive analyses of morbidity in the

MCH and CSHCN populations are underway. Furthermore, LAHIDD, which is administered within CHS, has provided the MCH program with data on annual discharges for asthma and non-fatal injuries among children.

In 2001 the state legislature passed a law creating the birth defects registry (LA Revised Statutes 40:31.41-31.48). This law authorizes OPH to obtain reports from hospitals and other sources. Administrative rules and regulations to ensure hospital compliance were approved and published in the May 2004 issue of the Louisiana Register (LAC 48:V.Chapters 161 and 163). These rules and regulations outline program procedures, confidentiality protocols, and reporting requirements for the surveillance system. Three medical records abstractors, called Birth Defects Investigators, were hired in July 2004, and another was added part-time in January 2005. Data collection began in February 2005. MCH/SSDI epidemiologists will assist registry staff in the analysis of collected data as well as in the preparation of reports for programmatic and policy use. Identification of children with disabilities and and/or CSHCN at birth will facilitate the provision of information to families about services available in their community and referral to early intervention if appropriate.

PRAMS allows for analysis of surveys administered to recent mothers and is the first systematic and ongoing population-based perinatal surveillance system in the state. The program is implemented by the joint efforts of MCH, the State Center for Health Statistics and CDC. PRAMS allows for the study of specific risk factors affecting pregnancy and the neonate. It also provides data for needs assessments and performance measures for Title V and Title X grants, social marketing campaigns, and infant mortality review among other projects. Data collection began in 1997 with Title V and Title X funding. In 2001 CDC, awarded Louisiana a PRAMS grant. Since program inception, LaPRAMS has maintained a 70% response rate meeting CDC criteria that allows state-level analysis of data. MCH epidemiologists have direct access to the PRAMS database and perform analyses and reports for dissemination.

19. 9 B. Data Capacity: Adolescent Tobacco Use: The percent of adolescents in Grade 9 through 12 who reported using tobacco products in the past month.

Part of the MCH SSDI coordinators scope of work is to garner information on adolescent health behavior. Information collected on this population is useful in guiding and evaluating alcohol, tobacco and drug control and prevention programs. MCH works with the Chronic Disease program that administers the Youth Tobacco Survey (YTS), to obtain information on adolescent health behavior. Currently MCH does not have direct access to the Youth Risk Behavior Survey (YRBS) conducted by the state Department of Education. Though the state participates in YRBS, the sample size is not large enough for valid statewide estimates for this age group. The YTS while it had a high response rate for 6th to 8th graders, had too low of a response rate from 9th to 12th graders to yield valid statewide estimates.

The Adolescent Health Initiative (AHI) collaborates with the DHH's Office of Addictive Disorders (OAD), to obtain information on adolescent alcohol, tobacco and drug use from the Communities that Care (CTC) survey. The study attempts to determine protective and risk factors for addictive behaviors. The most recent survey was administered to 6th, 8th, 10th and 12th graders in the fall of 2002 with a completion rate of 58.6%. A total of 125,092 students participated in the survey. Extensive Public Health Regional Reports as well as a statewide report of CTC data are available on the web, which compare Louisiana data to national CTC data. Data from these reports are available for program use.

One of the programs that utilizes CTC data is the Cullen Association Hope Center which provides the Life Skills Training Program homework assistance, standardized test remediation skills, and alternative activities for upper elementary and middle school youth (grades 4-8) to reduce exposure to identified risks for ATOD abuse. Another prevention contractor that uses CTC data is Mothers Against Drugs (MAD). MAD provides the One Great River and FACE programs. The One Great River program serves community and youth organizations representing diverse populations in the Northwest Louisiana (Region VII). One Great River is an alternative wilderness experience program

promoting health and prevention of tobacco, alcohol, other drug use and health risk behaviors among youth, ages 14-17. The FACE program is a family management skills training program for parents promoting health and prevention of tobacco, alcohol, other drug use and high-risk behaviors among children ages 9-12. The FACE program provides Preparing for the Drug Free Years (PDFY) workshops throughout Region VII.

19. 9.C Data Capacity: Overweight/Obesity: The ability of the state to determine the percent of children who are obese or overweight

This is an established indicator that measures the number of children aged 2- 5 years of age with a "Body Mass Index for Age" greater than or equal to the 95th percentile, as a proportion of all children aged 2- 5 years enrolled in Women, Infants and Children (WIC) clinics. The data is collected within the Pediatric Nutrition Surveillance System (PEDNSS, established and supported by the Centers for Disease Control and Prevention (CDC)). The data are collected statewide in a computerized WIC database system found within all WIC clinics and sent for analysis to the CDC. This process can take up to six weeks, as data quality is assessed and improved. Analysis may take at least 4 weeks, as state and national measures are generated to allow for comparisons. Not all states participate in PEDNSS therefore national measures are undercounted.

CSHS has initiated a data item to collect height and weight information on all CSHCN who attended CSHS clinics. This will allow for analysis of overweight/obesity status for CSHCN. Physical activity and other preventive programs can then be designed, implemented and individualized for this population. See State Performance Measure 05 for more information about childhood obesity.

IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

A. BACKGROUND AND OVERVIEW

Louisiana, like most of the Southeastern states, differs from the rest of the Nation in terms of its demographic profile and socioeconomic status. African-American births comprise 41% of total births black compared with 15% nationally. Because of this, the higher low and very low birth weight rates of black infants have a disproportionate effect on our infant mortality rate. Louisiana has one of the Nation's highest overall poverty rates and ranks 48th for child poverty. It ranks 49th for the rate of families headed by a single parent. It is a predominantly rural state with a low per capita income and also low literacy levels. These factors coupled with budget shortages experienced by the State present challenges to the Title V Program in achieving the goals of decreasing mortality and morbidity in the MCH population and assuring access to needed services.

The priorities that Louisiana has addressed in the past year that were established in the 2000 Needs Assessment have been: 1) Decrease infant mortality and morbidity, preterm births, and low birthweight; 2) Decrease mortality and morbidity among adolescents; 3) Decrease intentional and unintentional injury in the MCH and CSHCN populations; 4) Increase care coordination among CSHCN; 5) Assure that all children, especially those with special health care needs, have a medical home for comprehensive primary and preventive health care, with coordination of all health and support services; 6) Increase access to and utilization of comprehensive primary, preventive, and specialty care services for women of reproductive age, infants, children, adolescents, and children with special health care needs with particular emphasis on transportation and provider availability; 7) Assure the oral health needs of the MCH and CSHCN populations are met; 8) Address the social, emotional, and psychological needs of the MCH and CSHCN populations; 9) Assure early identification and referral of substance abuse, domestic violence, and child abuse and neglect; 10) Reduce unhealthy and risk taking behaviors of adolescents, pregnant women, and parents through public, professional, and patient education. As a result of the current Needs Assessment, the priority needs have been revised. Infant mortality, Access to quality Health Care, Oral Health, Mental Health, Injury Prevention, and Substance Abuse remain priority areas.

Outcome measure related to disparity in Infant Mortality for black and white infants is related to the physical health factors playing a role in infant deaths as well as issues unique to social, economic, and environmental factors and accessibility issues for the black population. The National and State Performance Measures highlight areas in which progress needs to be made in order to achieve success as measured by the Outcome Measures.

In 2003 there were improvements in the infant, neonatal, perinatal, and child mortality rates, which is a turnaround of the increases in these rates in 2001 and 2002, and continues the overall downward trend in our infant, neonatal, post-neonatal, perinatal, and child mortality rates that were seen until 2000. This is encouraging that the initiatives that the MCH Program instituted in the past few years to address the increasing mortality rates are having an impact.

In the past year, progress has been made in the majority of National and State Performance Measures. We have improved in the percentage of infants who received neonatal screening (NPM #1), immunization rates for children (NPM #7), teen pregnancy rates (NPM #8), motor vehicle crash deaths for children 14 years and younger (NPM #10), the percentage of newborns screened for hearing before hospital discharge (NPM #12), and the percentage of potentially Medicaid eligible children who received a service paid by the Medicaid Program (NPM #14). There were slight improvements in the Performance Measures for the percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates (NPM #17) and the percent of infants born to pregnant women receiving prenatal care beginning in the first trimester (NPM #18). There was an increase in the percent of uninsured children (NPM #13), the percent of very low birth weight infants (NPM #15), and the teen suicide deaths rate (NPM #16). There was no additional data to change in the National Performance Measures related to Children with Special Health Care Needs (NPM #2 -- 6) or the percent of third grade children who receive protective sealants (NPM #9).

The State Performance Measures that showed improvement are the percent of all children and adolescents that have access to school-based health center services (SPM #1), the percent of women in need of family planning services who received such services (SPM #2). The rate of children under 18 who have been abused or neglected (SPM #3), the percent of CSHS patients with case management (SPM#4), and the percent of licensed day care centers with a health consultant contact (SPM #10). There was no change in the epidemiology capacity (SPM #9). There was no additional data to change the percent of women who have had a baby reporting physical abuse (SPM #6), the percent of women who use substances during pregnancy (SPM #7) and the percent of children age 2 -- 5 on WIC greater than or equal to the 95th percentile for BMI for age (SPM #5). The Measure that showed a slight worsening trend was rate of infant deaths due to SIDS (SPM #11).

We feel confident that the approaches we have initiated to address the Priority Needs from the 2000 Needs Assessment and the operational plan we have developed to address the priority needs developed in the current needs assessment will have the positive outcomes we seek and ultimately will improve the National Outcome Measures.

B. STATE PRIORITIES

Priority Need 1: Decrease infant mortality and morbidity, preterm births and low birth weight. Related Performance Measures: National Performance Measures (NPM) 1, 8, 15, 17, 18 and State Performance Measures (SPM) 6, 7, 11 (formerly 8)

OPH operates 70 parish health units, located in 62 of Louisiana's 64 parishes, through which the MCH Program provides a safety net of health care for uninsured women and infants, and those with Medicaid coverage who have limited access to private providers. MCH funds community-based outreach, case management and home visiting programs for pregnant women and infants. A contract with the Medical Center of Louisiana in New Orleans addresses substance abuse for pregnant women and the Office of Addictive Disorders provides a substance abuse counselor to provide services in an MCH funded prenatal clinic in Monroe. MCH targets smoking cessation services for perinatal populations through a contract with the Louisiana Public Health Institute. MCH administers public information and media campaigns to reduce infant mortality promoting early prenatal care and healthy behaviors, SIDS risk reduction, and child abuse prevention. MCH assists parish and regional MCH and public health leaders to address the problem of infant mortality through data analysis, technical assistance and funding of interventions. Areas with high infant mortality rates are targeted, while the remaining areas are assessed to assure that the infrastructure and capacity is in place to care for high-risk pregnant women and those with access problems. In order to gather more detailed information on perinatal deaths, OPH has initiated the development of regional Feto-Infant Mortality Reviews (FIMR) in all regions. In addition, data collection on birth defects will help improve birth outcomes.

Priority Need 2: Decrease mortality and morbidity among adolescents. Related Performance Measures: NPM 13, 16, SPM 1

The Adolescent School Health Initiative Program funds and provides technical assistance to 53 state-funded, 1 federally funded, and 1 foundation-funded School Based Health Centers (SBHC). SBHCs provide primary and preventive physical and mental health services, which include medical and psychosocial history; physical examination; risk assessment; dental assessment; hearing and vision screening; immunizations; assessment of educational achievement and attendance problems; treatment of minor and acute problems; management of chronic problems; dispensing medications; referral for STD management; HIV testing and counseling; counseling and referral for physical and sexual abuse; conflict resolution/anger management skills; social service assessment; and health education. The OPH Family Planning Program (FPP) receives funding from Title V and provides comprehensive medical, educational, nutritional, psychosocial and family planning services to adolescents. One fourth of the patients served by the FPP are under age 20. The CSHS Program provides subspecialty care for adolescents with special health care needs. Adolescents comprise approximately half of the CSHS population. Transition issues focus on self-determination and

navigating the adult health care system. MCH funds the Louisiana Adolescent Suicide Prevention Task Force to develop the statewide plan on adolescent suicide prevention and implement training to school personnel on suicide prevention.

Priority Need 3: Decrease intentional and unintentional injury in the MCH and CSHCN populations. Related Performance Measures: NPM 10, 16, SPM 3, 6

The MCH funds Louisiana's SAFE KIDS program, a comprehensive injury prevention program that organizes local chapters throughout the state, distributes newsletters and pamphlets, conducts special events, and participates in health fairs. Interventions address car, gun and fire safety, childproofing homes, bicycle helmet use, and sports injury prevention. MCH has established Regional MCH Injury Prevention Coordinators who work to decrease unintentional injuries in children in each of the 9 regions. The Prevent Abuse and Neglect through Dental Awareness program distributes materials on recognizing and reporting signs of child abuse and neglect to all dentists and hygienists in the state. The Child Death Review Panel, established by the State Legislature in 1993, reviews all unexpected deaths in children under the age of 15. The MCH Program currently staffs a full time position for the Child Death Review Panel. CSHS provided leadership and funding for a special project to address prevention of secondary disabilities in CSHCN from birth to age 5.

Priority Need 4: Increase care coordination among children with special health care needs. Related Performance Measures: NPM 3, 5, 6, SPM 4

The CSHS Program will implement a care coordination model as part of the Long Range Plan. It will include medical home coordination as a component of the plan of care and promotion of health strategies, including primary, secondary and tertiary prevention of disabilities. The CSHS Care Coordination Program provides developmentally appropriate counseling. Parent participation in the program assures that the CSHS Program is family-centered and advocacy-focused. CSHS has had parent participation for over 14 years. Parent Liaisons attend CSHS clinics to offer emotional support and resources to families of CSHCN. Parent input into program policy and procedures occurs with 3 statewide parent coordinators who have collaborated with staff in the development of the Care Coordination model, continuous Quality Improvement, Universal Newborn Hearing Screening Systems, and the Medical Home project. The Part C program, Early Steps, also provides Family Service coordination for eligible children from birth to age 3.

Priority Need 5: Increase access to and utilization of comprehensive primary, preventive and specialty care services for women of reproductive age, infants, children, adolescents and children with special health care needs with particular emphasis on transportation and provider availability. Related Performance Measures: NPM 3, 4, 5, 7, 13, 14, SPM 1, 2, 4

MCH provides comprehensive health services to women of reproductive age, infants, children, and CSHCN who lack access to services due to financial or other barriers including the lack of providers. Children's Special Health Care Services provides subspecialty health care and care coordination services in 9 regional subspecialty clinics. MCH initiates services in areas of the state with access problems. Outreach workers are employed in high-risk areas of the state to assist patients overcome barriers to care. The CSHS Medical Home project specifically targets access and utilization of primary care by families of CSHCN.

Priority Need 6: Assure that all children, especially those with special health care needs, have a medical home for comprehensive primary and preventive health care, with coordination of all health and support services. Related Performance Measures: NPM 3, 4, 5, 6, 13, 14, SPM 4

The CSHS Program has taken a leadership role in the Medical Home Project for Louisiana. The goal is to assure that all children in the state have a medical home and activities are conducted in conjunction with the Louisiana Chapter of the American Academy of Pediatrics. The Community Care Program provides physician primary care case management for Medicaid clients. All children in CSHS medical clinics are screened for primary health care coverage, and families are referred to primary

care providers when the child has none. CSHS care coordination includes medical home coordination as a component of the plan of care.

Priority Need 7: Assure the oral health needs of the MCH and CSHCN populations are met. Related Performance Measure: NPM 9

CSHS funds a Dental Clinic for CSHCN in the New Orleans area. Services are provided by LSU School of Dentistry and are specially designed to be readily accessible to this population, known to have barriers to accessing regular dental care. This project also enhances training for dental students in providing care to CSHCN. CSHS provides assistance through DHH/OPH Regional Offices for non-Medicaid eligible children to receive routine dental services through the private sector. The Oral Health Program (OHP), in conjunction with the Fluoridation Advisory Board of Louisiana, works with non-fluoridated communities. The OHP provides funding and technical assistance for the fluoridation projects. The OHP assesses the oral health needs of children and adolescents in the state. The surveillance of 3rd grade school children is conducted every 5 years to assess their oral health, providing information on untreated caries, sealant prevalence, and the urgency for treatment. School-based sealant initiatives are being implemented in 4 regions. The OHP promotes the new Medicaid covered dental services for pregnant women with periodontal disease to pregnant women, prenatal providers, and dentists.

Priority Need 8: Address the social, emotional, and psychological needs of the MCH and CSHCN populations. Related Performance Measures: SPM 1, 3, 4, 6

Prenatal care services are directed at assuring maternal and fetal optimal health, healthy behaviors, minimization of risk factors and early recognition, treatment and referral of problems that may put mothers and infants at risk of morbidity directly related to infant mortality. MCH funds the Nurse Family Partnership (NFP) Program, a program for first time mothers of low socioeconomic status, in all regions of the State. MCH collaborates with the Office of Mental Health (OMH) to provide mental health support and services to the Program. OMH assigns mental health workers to the NFP team. CSHS Parent Liaisons organize and participate in support groups for families of CSHCN. MCH and CSHS have begun collaboration with the Early Childhood Supports and Services program of the OMH. This project provides mental health services to children from birth to age 5.

MCH has developed a new parenting newsletter series that is being printed and will soon be mailed to Louisiana parents. The series emphasizes developing healthy infant caregiver relationships, healthy social and emotional development, parent and parenting issues, and mental health concerns including maternal depression and family stress. A 30 hour Infant Mental Health Educational Series was developed by an Infant Mental Health Specialist in MCH. The series emphasizes attachment theory and current knowledge of infant social and emotional development. This Infant Mental Health Training is provided to public health staff, including CSHS staff, across the state. MCH has hired a Mental Health Coordinator who will assure that social-emotional health is part of all MCH interventions. CSHS is developing parent training modules to address issues experienced by families of CSHCN in lower socio-economic populations.

Priority Need 9: Assure early identification and referral of substance abuse, domestic violence and child abuse and neglect. Related Performance Measures: SPM 1, 3, 4, 6, 7

A risk assessment is conducted on all patients receiving comprehensive prenatal care in the parish health units, and includes questions about substance abuse and domestic violence. Referrals are made to local substance abuse treatment facilities and battered women shelters. A Prenatal Risk Assessment tool focusing on psychosocial risk factors, specifically substance use, domestic violence, financial/social service needs and mental health has been disseminated for use along with training for brief intervention. The MCH child health record is used to identify infants and children at risk for child abuse and neglect by looking at factors that have been associated with child abuse and neglect. MCH utilizes public health nurses to assist child protection workers in investigating suspected cases of medical neglect, malnutrition and failure through an interagency agreement with Office of Community

Services. CSHS, through Early Steps, has entered into an agreement with the Office of Community Services to provide for a mandatory referral of all children, birth to age 3, with substantiated abuse or neglect findings to the Part C System.

Priority Need 10: Promote healthy and reduce risk taking behaviors of adolescents, pregnant women and parents through public, professional and patient education. Related Performance Measures: NPM 8, 10, 16, SPM 1, 3, 7, 10, 11 (formerly 8)

Parish health units provide all women seeking prenatal care receive extensive counseling and education on prenatal risks and how to keep healthy. Topics include substance abuse, nutrition, exercise, signs of early labor, prevention of sexually transmitted diseases, breastfeeding and others. Pamphlets and videos are additional methods used in patient education. The OHP provides information to pregnant women through the WIC Program and the parish health units on the effects of periodontal disease and the possible consequences of pre-term delivery. Families of children receiving preventive services at the health unit are screened for environmental factors related to safety, injury prevention and lead poisoning. Material on injury prevention, lead poisoning prevention, and SIDS risk reduction are provided to families.

Partners for Healthy Babies, a social marketing campaign, uses communication and education strategies to reach both the MCH public and professionals concerning prenatal health. Communication is population-based and includes multi-media presentation and direct presentations (speeches, health fairs). A clearinghouse of resources and materials including audiovisuals and print material on perinatal substance abuse is maintained by MCH. These are made available and distributed to public and private providers, community organizations and individuals. OPH and Office of Addictive Disorders have an interagency agreement to jointly provide pregnancy testing in the OAD treatment facilities statewide.

SIDS risk reduction awareness and public education is implemented within high-risk target population areas of the state through the development of a social marketing public information campaign about safe sleep environment. The SIDS Programs' educational efforts target social workers, emergency medical staff, police officers and medical examiners statewide. The MCH Obesity Committee works on policies promoting and supporting healthy eating, physical activity and healthy weight among children. The MCH Program continues to expand its existing Child Care Health Consultant Initiative. Approximately 160 Child Care Health Consultants provide technical assistance, act as health resource and referral persons, and provide access to health care information. CSHS staff provides training to childcare centers in relation to CSHCN to increase access and improve services to children with disabilities who are enrolled in day care centers and Head Start.

C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective			95	95	95
Annual Indicator			93.6	95.2	94.2

Numerator			102	120	114
Denominator			109	126	121
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	95	96	97	97	97

Notes - 2002

Data is calendar year.

Notes - 2003

Without the match of newborn screening result data with birth records being conducted on a routine basis, numerators and annual indicators can only be an estimate. However, given the fact that all three labs started testing for the additional diseases on or before the diseases were added to the rule, the 95% level seems to be a reasonable estimate. In August of 2003, a rule was passed that specified required data fields to make matching more accurate. Routine matching is anticipated to be accomplished by summer of 2004. Data is for calendar year.

Notes - 2004

Data is for calendar year.

Without the match of newborn screening result data with birth records being conducted on a routine basis, numerators and annual indicators can only be an estimate. However, given the fact that all three labs started testing for the additional diseases on or before the diseases were added to the rule, the 95% level seems to be a reasonable estimate. It was hoped that the amendment to the newborn screening rule in 2003 that specified the essential data fields for the surveillance reporting would improve the accuracy of the matching. However, for some laboraotories, data fields are not being collected or appear on the lab specimen form, which has represented a significant barrier in recieving complete data. Another amendment has been submitted in June 2005 to further strengthen the surveillance reporting requirement. This time social security number of the infant's mother is a required data field. Routine matching is anticipated to be accomplished by spring of 2006.

a. Last Year's Accomplishments

In 2004 the Genetics Program screened approximately 65,302 newborns or over 95% of newborns born in Louisiana. Of the newborns identified with a positive screen, 94.2% were provided timely and appropriate follow-up. For positive screens, one was detected with classical PKU, 47 with congenital hypothyroidism, 97 with sickle cell disease, 1 with biotinidase and 2 with galactosemia. All newborns detected were followed up and on treatment within proper timelines except for 7 patients with sickle cell disease.

Population Based Services
Louisiana's newborn screening program screened for the following 5 conditions: phenylketonuria (PKU), congenital hypothyroidism, sickle cell disease, biotinidase deficiency, and galactosemia. Genetics staff provide timely follow-up on all positive screens to ensure early diagnosis and treatment. Long term tracking and follow-up is provided for metabolic and sickle cell patients. Follow-up for congenital hypothyroidism patients ends at the point of verification of treatment.

The Genetics Section ensures that greater than 95% of newborns are screened for all the diseases on the official battery by providing education to medical providers on the legislation and rule mandating screening, and by only allowing Office of Public Health (OPH) approved

laboratories to perform the tests on newborns. The project of matching newborn screening records with birth records was suspended while allowing for an upgrade of the State Central Laboratory's data management system for newborn screening and an amendment to the newborn screening rule to require laboratories report mother's social security number. The latter data field was found to be critical to the match process in earlier pilots.

Direct Services
Genetics Program continued to contract with medical geneticists to conduct regional genetics clinics at ten sites reaching 500 families, ensuring early detection and initiation into specialized care.

Enabling Services
Contracts were continued with Sickle Cell Foundations in 7 regions to provide patient assistance to families affected by sickle cell disease. A protocol for using the Parent Educational Manual was developed.

Infrastructure Building Services
Progress continued on the matching of the newborn screening lab data with vital records birth records data to determine the percentage of newborns receiving an initial screen.
The Louisiana Newborn Screening Advisory Committee (LNSAC) continued to meet on the expansion of screening through tandem mass spectrometry and improving the policy for repeat screening of transfused newborns. The LNSAC expanded membership representing endocrinology, hematology, pediatrics and various patient advocacy groups.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Universal newborn screening and follow-up conducted for 5 conditions.			X	
2. Conduct training sessions at hospitals to reduce unsatisfactory screening specimens.				X
3. Conduct regional genetics clinics at 10 sites staffed by a medical geneticist.	X			
4. Provide clinic-based wrap-around services by contracted sickle cell foundation staff.		X		
5. Educate adolescent PKU girls and high risk maternity staff on fetal effects of maternal PKU.		X		X
6. Provide an educational program for sickle cell patients and families.		X		
7. Provide an educational program for medical providers on metabolic diseases detected through tandem mass spectrometry.				X
8.				
9.				
10.				

b. Current Activities

Direct Services and Enabling Services
Genetics Program continues to conduct regional genetics clinics for evaluation and for the referral of metabolic patients identified through newborn screening. Contracts are continued for regional sickle cell foundations.

Population-Based Services
Five metabolic diseases were added to the newborn screening panel in November of 2004: argininosuccinic aciduria (ASA), citrullinemia, homocystinuria, maple syrup urine disease (MSUD) and medium chain acyl-coA dehydrogenase deficiency (MCADD). The addition of these diseases to the official newborn screening rule will be effective in the fall of 2005. Genetics Program continues to collaborate with the State Central Laboratory on the operation of a newborn screening and follow-up system to include universal testing with a panel of 10 diseases. Planning continues to use tandem mass spectrometry to its full capacity in the next year. Development of the other four components of the system to include follow-up, diagnosis, management and evaluation continue to be addressed.

Infrastructure Building Services
The Genetics Program has met a number of times with the Tulane Human Genetics Program to assist on development of a HRSA grant project entitled the Enhanced Genetic Services and Newborn Screening Collaborative in Region 3. The overall goal of this project is to utilize the unique established regional genetics infrastructure provided by the Southeastern regional Genetics Group, Inc. (SERGG, Inc.) for developing a regional approach to address the misdistribution of genetic resources and promote the rapid translation of genomic medicine into public health and health care services.

The Louisiana Sickle Cell Medical Council will continue to meet to develop a plan for transitional and adult care, and to address improvements in the current regional pediatric sickle cell system

c. Plan for the Coming Year

Objective: Increase to 96% the percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.

Direct and Enabling Services
The Genetics Section will ensure the provision of specialized medical and nutritional management for 100% of affected infants identified through newborn screening pursuant to the adoption of tandem mass spectrometry. Genetics will continue to contract with medical schools to cover patients identified through the expanded metabolic screening.

Population-Based Services
The Genetics Section will change the screening by use of the tandem mass spectrometry instrument from a pilot to an official part of the newborn screening panel by amending the newborn screening rule in the fall of 2005. LNSAC will meet to address how the state will expand this methodology to its full capacity and adopt screening for congenital adrenal hyperplasia. An upgrade of the State Central Laboratory's data management system will allow for the reporting of the results on the additional metabolic diseases, improve the interface with other databases such as the immunization registry, LINKS and improve the matching of screening and birth records.

Infrastructure Building Services
The Genetics Section will convene the Newborn Screening Advisory Committee to address the planned expansion using tandem mass spectrometry and screening for congenital adrenal hyperplasia. Increasing the availability of screening result data of patients for authorized medical providers will be evaluated and considered, such as inclusion of newborn screening specific data fields on the LINK System. Consideration will continue for consolidating the newborn hearing infrastructure with that of the newborn heel stick system.

The following objectives are planned for the purpose of improving both professional and parent/patient knowledge level: improve the medical community's knowledge level and understanding about expanded screening, screening protocols for transfused infants, and skill in blood specimen collection and provide CE offerings to high-risk maternity staff and to adolescent PKU girls on fetal effects of maternal PKU and to general medical providers on sickle cell services and care.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				60	60
Annual Indicator			55.2	55.2	55.2
Numerator					
Denominator					
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	60	60	62	62	62

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

Since 1992 Children's Special Health Services (CSHS) has provided Parent Liaisons (PL) through the non-profit organization Families Helping Families. All PLs are parents of a child with special health care needs (CSHCN). The PLs are located in the 9 regional OPH clinics the state, providing direct consultation and support to families. SLAITS data for 2002 indicated that 55.2% of families of children 0-18 with special health care needs in Louisiana reported that they partner in decision-making at all levels and are satisfied with the services they receive. The annual performance objective was 60% for 2004.

Direct and Enabling Services
CSHS provided paid PLs in every regional CSHS clinic. They were trained to offer support and

referrals to ensure that the families were getting the services that they needed. The statewide CSHS Parent Consultant and Statewide Parent Training Coordinator held training sessions with the PLs to assist with regional training needs. As a result of this support, the PLs provided workshops and support groups for the families that attended the CSHS clinics. The PLs were also trained to provide outreach to the community on issues relating to CSHCN, as well as to work as a team with the staff at the CSHS clinics. In this way, the PLs were able to share information with the staff and determine where particular needs existed for parents. The support provided by PLs enabled families to be active partners in decision-making at all levels.

Population Based Services
CSHS facilitated family education by inviting families to attend workshops and trainings. Parents were invited to participate as speakers and CSHS advocated for parents to be represented in other agency decision-making process and supports. CSHS facilitated family participation in numerous trainings by providing stipends to families to enable them participate. The PLs contracts also included funds that allowed them to attend the Parent to Parent conference.

CSHS also hired Community Outreach Specialists (COS) for EarlySteps, Louisiana's Part C early intervention system. The COSs were parents of young children who have a developmental delay and have received services through the Part C Office of Special Education System in the past. These parents participated in Regional Interagency Coordinating Councils (RICC), focusing on issues relevant to serving infants and toddlers with developmental disabilities or medical conditions with a high probability of resulting in a developmental delay. They also provided one-on-one assistance to families to inform them about services for their children.

Infrastructure Building Services
CSHS employed several paid parent consultants to assist with bridging the gap between the program and families and to assist with representation of family views in policy making. These included a CSHS Parent Consultant, CSHS Statewide Parent Training Consultant, Hearing, Speech and Vision Statewide Parent Coordinator and EarlySteps/Part C Parent Consultant.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Employ Parent Liaisons in all CSHS offices.		X		
2. Include parents in policy decision making at all levels.				X
3. Provide ongoing training for Parent Liaison staff.				X
4. Provide wrap-around services for all children in CSHS clinics.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Direct and Enabling Services
CSHS continues to empower families served in the nine regions by offering PL support to

families. By providing direct consultation with families, CSHS continues to strive to ensure that families are informed about services and on how to be active participants in all decisions about their child's services.

Population Based Services
CSHS collaborated with families and community partners to present several programs that assisted families to be active partners in decision-making for their children and in being better consumers with services for their children. The Parent Liaisons participated in planning for a Medical Home training programs in Region 9. The PLs also presented statewide workshops on such topics as seizures, autism and disability rights.

The EarlySteps COSs worked to inform families about participating in Part C RICCs. Through such participation, families were able to work with health care professionals on addressing regional needs for serving children with developmental disabilities.

Infrastructure Building Services
CSHS continues to provide stipends for families to attend trainings throughout the state. CSHS also continues to provide funding for the PLs in all the nine regions to work with families in a clinical setting. Thirty parents where included as Regional Team Members at the CSHS Statewide conference where the needs assessment was discussed and Regional Teams made recommendations regarding the Long Range Plan for CSHS.

c. Plan for the Coming Year

Objective: 60% of families of children with special health care needs age 0 to 18 years will report that they partner in decision making at all levels and are satisfied with the services they receive.

Direct and Enabling Services
CSHS will continue to employ PLs to work with families in the clinical setting. CSHS will also continue to offer trainings to the regional PLs to enhance their skills in providing services to families, as well as how to assist parents to navigate the complex health care systems and evaluate quality services for their children.

A unique parent training aimed at promoting independence in navigating the system of services will be developed in the upcoming year. This training will be geared to families currently eligible for CSHS and have multiple barriers to obtaining services for their children. In addition, it will be incorporated as the role of the parent liaisons in care coordination activities for CSHS.

Population Based Services
CSHS will continue to provide trainings for families to assist them in being active partners in decision making for their children. CSHS will also continue to facilitate trainings, which will provide information to families to assist them in being better consumers of services and in learning how to participate in local and statewide systems to address services.

Infrastructure Building
CSHS will continue to partner at the statewide and local levels to facilitate inclusion of parents in decision making for their children with special health care needs. CSHS will also continue to employ paid parent consultants at both the state and local levels and include them in programmatic policy making. CSHS will utilize parent consultants and parents of children enrolled in the program to evaluate the results of the needs assessment and in developing long-range plans for the program. The program will also incorporate the input of young adults with special health care needs as well as self-advocates. Parents continue to be a strong force and input into the way services are provided under Title V.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				55	50
Annual Indicator			48.8	48.8	48.8
Numerator					
Denominator					
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	50	50	55	55	55

Notes - 2002
The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003
The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004
The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

SLAITS data for 2002 indicated that 48.8% of children with special health care needs in Louisiana received coordinated, ongoing comprehensive care within a medical home (MH). The annual performance objective was 50% for 2004.

Direct and Enabling Services
CSHS care coordination services provided screening of all children in CSHS clinics for accessibility and utilization of "Medical Home" services. Children without primary health care coverage were directed to appropriate services in the community. Those eligible for LaCHIP were enrolled and linked to a primary care provider (PCP) as part of Medicaid's ongoing "Community Care Program". A new transitioning program was begun. Adolescents, age 14, and their families, received "transition services" to begin the process of transitioning to adulthood and to adult health care providers. They received a packet of information regarding transition with self-exploratory exercises and met with the clinic social worker to address individual needs and concerns.

Population-Based Services
Regional medical home trainings were held in Houma in October 2003 and Monroe in April 2004 to increase the capacity of pediatric health care providers to provide medical homes for CSHCN. This brings the total number of regions with medical home trainings to four. Beginning

in April 2003, CSHS participated in the Medical Home Learning Collaborative national training sessions and established partnerships with three pediatric practices through the Medical Home Initiative grant. Two of the pediatric practices completed collaborative activities and hired care coordinators, enabling them to improve all components of a MH within their practices. A third practice, LSU TigerCare Pediatric Faculty Practice Clinic, was selected for future medical home activities. Because this practice is a teaching site for LSU Pediatric Residents, this will permit training in the medical home concept at the pediatric medical student and resident level.

Infrastructure Building Services
CSHS contracted with Louisiana State University Health Sciences Center Early Intervention Institute (LSUHSC EII) to perform a Long Range Plan Needs Assessment to determine the resources/capacity of each area of the state, including PCP's that provide MH services for CSHCN and CSHCN with Medicaid. Specialists were also surveyed to determine specialty shortage areas to identify barriers to comprehensive care. Data was collected from July 2003 until June 2004 and presented in October 2004.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide regional Medical Home Programs.			X	
2. Provide population based care coordination.			X	
3. Provide screening and referral to primary care practices.		X		
4. Incorporate medical home model into LSU pediatric resident training.				X
5. Support transition services for adolescents.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Direct and Enabling Services
In CSHS clinics, staff continues to screen and refer all children for primary health care coverage at each clinic visit and to assist families in locating and accessing MH services. CSHS also continues its transition program for all children age 14 who attend CSHS clinics and is expanding this to include children ages 14 and 15.

Population-Based Services
MH activities continued in two pediatric practices through the Medical Home Initiative grant. One of these is a busy rural practice that is identifying CSHCN within the practice and providing care coordination and linkages to community services. A second practice is a busy inner city Medicaid practice that identified CSHCN and provided care coordination services until March 2005. The care coordinator for that practice was moved to a third practice that is an LSU faculty practice teaching clinic for pediatric residents. A new care coordinator will be hired for the second practice to continue its MH activities. The third practice, LSU TigerCare Pediatric Clinic, is currently establishing a database for CSHCN. Baseline data have been collected regarding the "medical homeness" of the practice and baseline parent satisfaction surveys are currently being completed. A workshop was held for LSU faculty and clinic staff on the MH concept in March 2005, and care coordination activities have begun. A data entry system has been

developed to track care coordination activities and to aid in determining whether these result in increased parent satisfaction and decreased ER visits and hospitalizations. Finally, a new model has been developed for regional teams to spread the MH concept to private pediatric offices. Teams will conduct lunchtime seminars for pediatricians and their office staff and will provide information on local community and public health resources for CSHCN. The model was presented to Region IX and will be implemented later this year.

Information was provided to all pediatricians in Louisiana regarding the Part C program, EarlySteps, as well as the Early Hearing Detection and Intervention (EDHI) program. By informing physicians of available resources, accessibility to and performance of medical homes in Louisiana is enhanced.

Infrastructure Building Services
Results from the Long Range Plan Needs Assessment were presented in October 2004 and discussed by regional teams at the Annual 2004 CSHS Conference. Regional teams comprised of physicians, CSHS staff, OPH Regional Administrators and Epidemiologists, parents of CSHCN and community partners who attended the Annual Conference were used to devise possible solutions to barriers identified in the Long Range Needs Assessment for CSHCN in accessing both MH and specialty services and to develop recommendations for their region about the future of direct services in CSHS. Suggestions from these regional teams will be used to implement the CSHS Long Range Plan.

c. Plan for the Coming Year

Objective: To increase to 50% the percent of children with special health care needs, age 0 to 18, who receive coordinated, ongoing, comprehensive care within a medical home.

Direct and Enabling Services
CSHS will transition some of its services from direct specialty care in CSHS clinics to population based care coordination activities. Determination of clinics for transition will be done on a clinic-by-clinic and region-by-region basis, based on availability of private sector specialty services in the region and the recommendations from regional teams. Care coordination in CSHS clinics will be strengthened with emphasis on addressing barriers to access identified in the Needs Assessment. CSHS clinics staff will continue to link all CSHCN to medical homes. CSHS will expand adolescent transition services in 2006 to serve children ages 14 through 16 years of age.

Population-Based Services
CSHS will pilot care coordination activities in selected regions for CSHCN conditions where specialty services are available in the private sector. CSHS will continue to provide and train care coordinators for three pediatric practices to develop model medical homes that can be resources to other providers. Using the LSU faculty practice clinic and resident conferences, CSHS will incorporate the MH model into LSU pediatric resident training. The success of these activities will be documented with data collection at the LSU faculty practice clinic. If successful in Region IX, CSHS will take its latest MH training model to other regional teams for implementation in the four regions where trainings have not yet occurred. This will increase the capacity for MH for all CSHCN in Louisiana.

Infrastructure Building Services
CSHS will use data from the Long Range Plan Needs Assessment and regional team recommendations to identify barriers to accessing medical homes for CSHCN throughout the state and to develop strategies to overcome them. Some of the barriers identified in the Needs Assessment include lack of providers who take Medicaid, lack of PCP's and specific types of specialists in rural areas, and lack of transportation to medical appointments. To address these barriers, CSHS will increase care coordination activities for CSHCN throughout the state in

private pediatric offices through continued medical home trainings, and in CSHS clinics through the development of expanded care coordination activities. CSHS will continue to raise awareness of CSHS services in private pediatricians and to facilitate the provision of medical homes by increasing the availability of care coordination services and specialty expertise. CSHS will continue to convene regional teams to increase the capacity of PCP's to provide medical homes for CSHCN statewide. This will be accomplished by bringing families, young adults, OPH administrative staff and private health care providers together within regions to plan and implement MH programs and systems as described above.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				55	57
Annual Indicator			51.9	51.9	51.9
Numerator					
Denominator					
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	55	55	57	57	57

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

According to the 2002 SLAITS data 51.9% of families with children with special health care needs felt that they had adequate insurance to meet their needs. The annual performance objective was 55% for 2004. Much of Louisiana is extremely rural and there is a large portion of the general population that is uninsured. Many families obtain health care through the statewide system of Charity Hospitals. It should be noted, however, that of those families who did have some type of insurance coverage, 38.8% felt that the coverage was not adequate to meet their needs.

Direct Services
Clinic staff in each of the nine regions were asked to screen all children during regular clinic visits for insurance coverage and make referrals as needed. For those families with coverage, information in the clinic chart was checked for accuracy and updated if necessary. Families were counseled concerning eligibility requirements and referral procedures, and given assistance to complete forms if needed. Staff also assisted families who had private insurance policies with any issues that they may have concerning their policies. Families were advised to enroll in the LaCHIP program if they were eligible. Also, for those families who were Medicaid recipients, staff assisted them with the procedure for getting Community Care referrals from their primary care physicians if they needed assistance in doing so.

Enabling Services
Brochures outlining the services of various agencies (SSA, LaCHIP, etc) were provided in the waiting areas as well as from social workers and parent liaisons. Staff was available to answer questions as needed. In addition, during the last calendar year, Children's Special Health Services (CSHS) was instrumental in facilitating the use of a combination application form under EarlySteps, Louisiana's Part C System, which can be used to apply for EarlySteps, CSHS, and for services within the Office of Citizens with Developmental Disabilities and Medicaid. This facilitated family's application for Medicaid and LaCHIP.

Population-Based Services
In addition to meeting with families during clinic visits to assess their needs and assisting them with referrals to programs for which they might be eligible, CSHS staff was also instrumental in providing physicians and allied health professionals with necessary information for patients' various insurance policies so that payment could be obtained. Staff also assisted families when referrals were made to facilities other than their regular clinic site, including the Charity Hospital system.

Infrastructure Building
In order to meet the needs of CSHS patients, staff worked to build relationships with both public and private insurance entities that cover CSHS patients. They worked with various companies to ensure that needed services were covered. Staff also worked to make sure that all children had a Medical Home who accepted the family's funding sources.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborate with Medicaid and State Insurance programs to assure coverage.				X
2. Inform families of available services and programs.		X		
3. Provide informational materials to families in the clinical setting.		X		
4. Work directly with families to link to services.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Direct Services
Staff continues to screen families and update insurance information, at least annually, for all patients during clinic visits. For those families who are uninsured and/or who might qualify for SSI, appropriate referrals were made. Any issues pertaining to insurance (whether public or private) were dealt with on an as needed basis.

Enabling Services
Brochures for various public programs continue to be available in all clinic waiting areas and from social workers and parent liaisons. Staff works to assist patients and assure that families have a clear understanding of their particular insurance carrier--whether public or private. This often entails working with various companies to make sure that services are adequately covered in addition to ensuring that families understand what they need and how to navigate their particular service system.

Population-Based Services
Staff continues to work with CSHS patients and their insurance carriers to ensure that all necessary services are adequately covered. Staff also continues to work with physicians and other providers to supply sufficient information to insurance providers without delay. Staff also continues to work with families in getting appropriate referrals from primary care physicians.

Infrastructure Building
Staff continues to build relationships with public and private insurance agencies to assist patients in getting their needs met. Staff continues to work with Medicaid to bring attention to the special needs of families and to facilitate a seamless system of service delivery with the detailed information obtained in the needs assessment and the regional medical home projects. Private primary care physician offices will be encouraged to accept Medicaid and CSHCN in their practices, expanding accessibility of medical home.

c. Plan for the Coming Year

Objective: 55% of families of children with special health care needs ages 0-18 will report that they have public or private insurance that is adequate to meet their needs

Direct Services
During the upcoming year staff will continue to work to link CSHS patients and their families with agencies that provide appropriate insurance coverage.

Enabling Services
CSHS will continue to provide informational brochures for families. Staff will assist, as needed, with the completion of forms. CSHS will continue to work with other state agencies to ensure that families are familiar with any programs within that state for which they might be eligible.

Population-Based Services
During the upcoming year, clinic staff will work to increase awareness of state/federal programs that serve children with special health care needs. Clinic social workers will continue to meet with families during clinic visits to assess needs and make referrals. Social workers will also discuss with families any insurance issues and assist the family with advocacy efforts to address these issues with the multidisciplinary team to facilitate communication between CSHS and insurance carriers.

Infrastructure Building Services
CSHS will continue to partner with Medicaid to assure that appropriate children are enrolled. Medicaid will continue to be invited to exhibit and/or speak at future CSHS trainings to disseminate informational materials. CSHS staff will also continue to work with Medicaid and private insurance companies so that all prescriptions and necessary paperwork are submitted

timely so that patients can receive needed prescriptions, durable medical equipment, etc. The regional medical home projects will incorporate goals of expanding accessibility to Medicaid covered children, as well as CSHCN.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				70	70
Annual Indicator			68.8	68.8	68.8
Numerator					
Denominator					
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	70	70	75	75	75

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

Children's Special Health Services (CSHS) provided accessible services in all nine regions of the state for families of children with special health care needs, with emphasis on linking families to community based services. SLAITS data for 2002 indicated that 68.6% of families in Louisiana reported that community based services were organized so that they could use them. The annual performance objective was 70% for 2004. CSHS will utilize future National CSHCN surveys to measure progress of this objective.

Direct and Enabling Services
CSHS staff, including Parent Liaisons, provided direct information and referral to families who attended CSHS clinics. CSHS Parent Liaison staff also presented workshops and trainings for families on a wide variety of topics including community services, parenting skills and knowing your rights. CSHS continued close collaboration with regional Families Helping Families agencies that provided information and referral for families throughout the state.

Population Based Services
CSHS Parent Liaisons provided trainings to families statewide regarding community-based services. In addition, Parent Liaisons, in conjunction with Families Helping Families, were able to link families to needed resources through their large up to date referral system. CSHS also published a newsletter that was sent to families receiving services in CSHS, as well as families on the Families Helping Families database. This newsletter included community and statewide events, as well as updates on community and state services that may affect children with special health care needs.

Infrastructure Building Services
CSHS provided parent support services through Parent Liaisons, in all 9 OPH regions of the state. These parents provided direct consultation to families in CSHS clinics, as well as community-based trainings statewide. Parent Liaisons were trained about different agencies in our state, including but not limited to CSHS.

The Part C system of early intervention services was transitioned to CSHS on July 1, 2004. This change brought increased collaboration with Medicaid, Office for Citizens with Developmental Disabilities, Office of Mental Health and Office of Family Support to enhance systems for serving children with developmental disabilities. To assist families, a single application form was adopted for use in EarlySteps (Part C), OCDD and Medicaid. This single application is accepted as entry into each of the systems and makes access to services easier for families.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Assist families in accessing community-based services through Parent Liaisons.		X		
2. Support CSHS community-based clinics in all regions of the state.	X			
3. Provide workshops and support groups in community-based locations statewide.		X	X	X
4. Inform families about how to access community-based services.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Direct and Enabling Services
CSHS continues to offer support systems for families in the clinic setting, with emphasis on linking families to community resources. CSHS also instituted a transition program for all children, age 14 and up, who attend CSHS clinics in all nine regions of the state. A component of this system is to assist adolescents and their families in locating and utilizing needed community-based services. Parents in each of nine CSHS offices were trained to implement transition in clinic setting.

Population Based Services
CSHS continues to offer trainings to families statewide so that they can stay informed and knowledgeable about community resources and how to navigate systems to access services. CSHS also continues to publish a newsletter entitled Family Matters to families served in CSHS and through Families Helping Families. This newsletter informs families about changes in their state. It also informs them about trainings available, information about participating in advocacy, and new services available.

Infrastructure
CSHS continues to provide services to the nine regional areas of the state making services accessible to the families. CSHS also continues to work in partnership with community agencies to develop mechanisms for sharing information and making certain that information is easily accessible for families. CSHS continues to collaborate with all nine Families Helping Families agencies, as well as other parent advocacy agencies to assure family participation in design of systems for ease in use.

CSHS and the Part C system continue to collaborate with the Office of Mental Health and their Early Childhood Supports and Services Program to reduce duplication of effort in serving children with mental health issues. Stakeholders in Region IV have begun a pilot effort to combine meetings to address common issues

c. Plan for the Coming Year

Objective: 70% of families of children with special health care needs age 0 to 18 will report that community-based service systems are organized so they can use them easily.

Direct and Enabling
CSHS will continue to have Parent Liaisons in the nine regions of the state, providing direct consultation to families receiving services in the CSHS clinics. CSHS will expand transition services in 2005 to serve children ages 14 and 15. A component of the transition services addresses linking families to needed community based services

Population Based Services
CSHS will continue to train Parent Liaisons so that families are well informed and can take advantage of the of the community based resources to assist parents in caring for their special needs children. CSHS will continue to publish a newsletter to families served in CSHS and through Families Helping Families. The Birth Defects Registry and the EarlySteps System will join with the Newborn Hearing Screening Program in early identification of children with disabilities and chronic medical conditions and facilitate referrals as early as possible to CSHS, Part C system and other community resources and family support.

Infrastructure Building and Services
CSHS will continue to provide services to the nine regional areas of the state, making the services accessible to the families who utilize the services. CSHS will also work closely with community agencies to develop mechanisms for sharing information and making sure that information is easily accessible for families.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)*

Tracking Performance Measures *[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*					
Annual					

Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective					10
Annual Indicator			5.8	5.8	5.8
Numerator					
Denominator					
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	6	6	10	10	10

Notes - 2002

Because only one of the States (Maine) met the NCHS standards for reliability for PM 6, the 2002 indicator is the national average except for Maine which has its State value noted.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

SLAITS data for 2002 indicated that 5.8% of youth in Louisiana received the services necessary to make transition to all aspects of life. The objective was to increase to 6% youth with special health care needs who receive the services necessary to make transitions to all aspects of adult life.

Direct and Enabling Services
Children's Special Health Services (CSHS) initiated a formal transition process for staff to use with all adolescents/young adults who reached the age of 14 in 2004. This was a "phase in" system with plans to add one age group per year. CSHS staff screened all patients at CSHS clinics who were age 14 and provided necessary information and educational materials pertaining to transition to them and their families. One component of the information provided and reviewed with the family and adolescent was the "Life Map" which assessed information needed by family over a number of comprehensive areas. Transition services continued for other adolescents/young adults, but not in such a formalized manner.

Population Based Services
CSHS staff provided age appropriate services to all transition-age patients and their families who attended CSHS clinics. The adolescent/young adult patient and his/or her family were encouraged to attend conferences and seminars on transition services throughout the community such as those offered by Families Helping Families. CSHS collaborated with LSU and Families Helping Families on the Youth Leadership Forum that brings adolescents/young adults with disabilities together from all over the state to develop leadership skills, advocacy skills and promote independent living.

Infrastructure Building Services

CSHS completed a formalized transition plan to use with children attending CSHS clinics. CSHS also began collaboration with the multi-agency Transition Task Force that was reestablished, which included Louisiana Department of Education, Louisiana Rehabilitation Services, and the Office for Citizens with Developmental Disabilities.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide education to adolescent and young adult clients and their families concerning transition.		X		
2. Create partnerships to provide transition information to adolescent clients and their families.				X
3. Screen all adolescents and young adults according to transition policy.		X		
4. Assist with the acquisition of services necessary to promote self-reliance and self-determination.		X		
5. Collaborate with the multi-agency Transition Task Force to work on issues related to transition.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Direct and Enabling Services
CSHS continued the formalized transition process in CSHS clinics to use with all adolescent/young adult patients aged 14 and added the 15-year-old age group this year. Patients have an initial transition screening, which is updated annually. Additional age groups will be added after an evaluation of the effectiveness of the process. CSHS staff continues to provide necessary information and educational materials as well as training opportunities for adolescent/young adult patients and their families pertaining to transition services.

Population Based Services
CSHS continues to refer young adults and/or family members to transition programs provided in communities such as those offered by Families Helping Families. It also encourages participation in such programs as the Youth Leadership Forum to encourage leadership skills, advocacy skills and encourage independent living.

Infrastructure Building Services
CSHS continues to facilitate the educational needs of staff that work with CSHS patients reaching transition age. This year site visits were held in five of the nine OPH Regions to train staff in the implementation of the transition plan. The remaining four regions received their training at CSHS central office. CSHS collaborates with the Louisiana Department of Education and Louisiana Rehabilitation Services and the Office for Citizens with Developmental Disabilities to develop a team approach to the transition of CSHCN to adulthood and independence through the Transition Task Force. CSHS also joined the Governor's Office on Disability Affairs to study and provide input on a plan to see that adolescents/young adults with special health care needs have access to transportation throughout the state since this was

found to be a need when CSHS completed the Long Range Plan needs assessment this year.

c. Plan for the Coming Year

Objective: 6% of youth with special health care needs will report that they are receiving the services necessary to make transitions to all aspects of life.

Direct and Enabling Services

CSHS will continue a formal transition process to use with all adolescent/young adult patients ages 14 & 15 who attend CSHS clinics. Patients will have an initial screening, which will be updated annually. Additional age groups will be added after an evaluation of the effectiveness of the programs. CSHS will continue to provide necessary information and educational materials as well as training opportunities for adolescent/young adult patients and/or families pertaining to transition services.

Population Based services
CSHS will continue to refer young adults and/or family members to transition programs provided in communities such as those offered by Families Helping Families. CSHS will also encourage participation in the Youth Leadership Forum.

Infrastructure Building Services
CSHS will continue to facilitate the educational needs of staff that work with CSHS patients reaching transition age. CSHS will continue collaboration within the Louisiana Department of Education, Louisiana Rehabilitation services, and the Louisiana Office for Citizens with Developmental Disabilities to develop a team approach to transition of CSHCN to adulthood and independence. CSHS will continue to work with the Governor's Office on Disability Affairs to study and provide input on a plan to ensure that adolescent/young adults, with special health care needs have access to transportation throughout the state.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	88	90	80	70	72
Annual Indicator	71.8	64.1	61.9	69.9	72.6
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**

Annual Performance Objective	74	80	86	88	90

Notes - 2002

Data is from the National Immunization Survey (NIS). Only total percentages are provided in the NIS tables - numerator and denominator data is not included.

The National Immunization Survey (NIS) has a sample size of about 30,000 children. However, the sample is not the entire population, and thus sample estimates and population values are likely to be different. The magnitude of the likely difference is quantified through the 95% confidence interval. For example, in 1998, the vaccination coverage estimate for 3 doses of poliovirus vaccine in Alabama was 91.4% +- 3.2%. This means that the true coverage was probably between 88.2% and 94.6%. When comparing two estimates (e.g., between states or between years), an overlap in the confidence intervals indicates that the observed difference might be due to chance.

Notes - 2003

Data is from the National Immunization Survey (NIS). Only total percentages are provided in the NIS tables - numerator and denominator data is not included.

The National Immunization Survey (NIS) has a sample size of about 30,000 children. However, the sample is not the entire population, and thus sample estimates and population values are likely to be different. The magnitude of the likely difference is quantified through the 95% confidence interval. For example, in 1998, the vaccination coverage estimate for 3 doses of poliovirus vaccine in Alabama was 91.4% +- 3.2%. This means that the true coverage was probably between 88.2% and 94.6%. When comparing two estimates (e.g., between states or between years), an overlap in the confidence intervals indicates that the observed difference might be due to chance.

Notes - 2004

Data is from the National Immunization Survey (NIS). Only total percentages are provided in the NIS tables - numerator and denominator data is not included.

The National Immunization Survey (NIS) has a sample size of about 30,000 children. However, the sample is not the entire population, and thus sample estimates and population values are likely to be different. The magnitude of the likely difference is quantified through the 95% confidence interval. For example, in 1998, the vaccination coverage estimate for 3 doses of poliovirus vaccine in Alabama was 91.4% +- 3.2%. This means that the true coverage was probably between 88.2% and 94.6%. When comparing two estimates (e.g., between states or between years), an overlap in the confidence intervals indicates that the observed difference might be due to chance.

a. Last Year's Accomplishments

The immunization levels of children 24 months of age in Louisiana with 4 Diphtheria, tetanus, acellular Pertussis (DTaP), 3 Polio, 1 Measles-Mumps-Rubella (MMR), 3 Haemophilus Influenza Type B (HIB) and 3 Hepatitis B (HBV) was determined to be 72.6% by the National Immunization Survey (NIS) compared to the national average of 80.5%. The Immunization Program is implementing the Shots for Tots by One campaign to optimize vaccination coverage of children up to 12 months of age by utilizing an accelerated immunization schedule. This accelerated schedule allows the intervals between vaccine doses be reduced to the minimum allowable interval in order to maximize the number of immunizations given to get vaccine delinquents up-to-date. Recent studies have shown one out of three children have not received the recommended vaccines by 2 months of age.

Direct Services

The MCH Program has fostered support by covering the cost of vaccinations for children served throughout the local parish health units (PHUs) statewide. Approximately 13,000 children-visits statewide for immunization services were conducted by PHUs and included over 41,000 doses of vaccines administered.

Infrastructure Building Services
During this period, more education, information and quality assurance visits were conducted for our providers to ensure immunization best practices and simultaneous administration of vaccines. The Immunization Program continued to work with our coalitions comprised of physicians, nurses, voluntary agencies, political leaders, churches, and community organizations. These diverse groups have come together specifically to improve immunization coverage, and the coalition continues to work and oversee the Shots for Tots plan as we make progress toward our goal. The 12th annual Shots for Tots Conference was held December 2003 in New Orleans. The goal of the conference was to provide information for participants in providing comprehensive immunization coverage for all age groups and to explore innovative strategies for developing programs and policy. Continuing education credits were available to attendees.

The state immunization registry, Louisiana Immunization Network for Kids Stateside (LINKS) has continued to expand despite a temporary setback in the recruitment pace due to the smallpox phase I campaign. Once the smallpox campaign had been completed, LINKS continued to target recruitment of the 30% of the Vaccines for Children (VFC) providers that give 80% of the immunizations, and receiving data transferred from Medicaid. By the end of 2004, LINKS grew to include 1.3 million patients with over 12.3 million vaccinations entered in the system. Currently, over 400 provider sites are using the LINKS system to access patient data.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Supply vaccines to enrolled providers through the Vaccines for Children (VFC) program.			X	
2. Register birthing hospitals as VFC providers to offer first dose of Hepatitis B free to all newborns.				X
3. Expand on-site VFC/AFIX (Assessment Feedback Information Exchange) active provider sites.				X
4. Expand the Louisiana Immunization Network for Kids Statewide (LINKS) database for multiple providers.				X
5. Provide immunizations in public health units monitored by CASA reviews.	X		X	X
6. Collaborate with 11 statewide Infant Immunization Initiatives Coalitions.				X
7. Annual Shots for Tots Conference.				X
8.				
9.				
10.				

b. Current Activities

Direct Services

While the decline in immunization provisions in public health units have become evident, enhancing immunization coverage as a collaborative venture between private providers and public health units remain as the primary goal for the program.

Infrastructure Building Services
During this period, the expansion of VFC/AFIX (Vaccines For Children/Assessment Feedback Incentive and Exchange) onsite visits are being conducted with our provides to include education, information and quality assurance to ensure immunization best practices, increase immunization coverage levels and the simultaneous administration of vaccines. The enrollment of VFC providers has increased by 4.3% from the previous year with a simultaneous 14% increase in provider site visits. The Immunization Program will continue to work with the coalitions comprised of physicians, nurses, voluntary agencies, political leaders, churches, and community organizations. These diverse groups come together specifically to improve immunization coverage in Louisiana, and the coalitions will continue to work and oversee the Shots for Tots plan as we make progress toward our goal. The 13th annual Shots for Tots Conference was held December 2004 in New Orleans.

LINKS continues to expand since the successful completion of the smallpox campaign. As the registry continues to progress, the Office of Public Health continues to demonstrate the value of the LINKS system by using data to support various public health initiatives in Louisiana such as: a) support of the Strategic National Stockpile Drill; b) collaborative arrangement with the Strategic National Stockpile; c) integration of lead data; d) implementation of the HEDIS module; e) utilizing HL7 technology, and f) development of a School Nurse module.

c. Plan for the Coming Year

Objective: Increase to 80% the proportion of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.

Direct Services
While the decline in immunization services in public health units have become evident, enhancing immunization coverage as a collaborative venture between private providers and public health units remain as the primary goal for the Immunization Program and to achieve the

2010 Health Objectives. The Immunization Program will provide vaccines to all VFC-eligible children with an estimate of over 1million doses to be distributed.

Infrastructure Building Services
The projected plan for year 2005-2006 will continue with the expansion of VFC/AFIX onsite visits and LINKS recruitment of immunization providers as program priorities. This expansion includes the ongoing provision of education, information and quality assurance to ensure immunization best practices, increase immunization coverage levels and the simultaneous administration of vaccines. The Immunization Program plans to enhance immunization coverage in Louisiana through the adoption and implementation of the Shots for Tots by One campaign. These efforts are aimed at optimizing childhood immunizations for protection against 12 different childhood diseases by the completion of approximately 20 doses of various vaccines required by 12 months of age.

LINKS continues to expand since the successful completion of the smallpox campaign. The recruitment of the remaining 10% VFC enrolled providers, as well as all newly enrolled providers, to participate in the LINKS system will be conducted. Several phases of the LINKS system will be implemented in the upcoming years. Currently, the School Nurse module is being developed and piloted before the full implementation to public school nurses statewide.

School Nurses will utilize LINKS to assess immunization coverage of students from pre-Kindergarten through 12th grades. A provider tracking module is in the developmental stages as a means to track, evaluate and validate the LINKS enrollment process among private providers as LINKS end-users. Lastly, a lead screening module is in progress to integrate additional child screening information within the LINKS system for health care providers on childhood lead screening.

The 14th annual Shots for Tots Conference is being planned and scheduled for December 2005 in New Orleans. Continuing education credit will be awarded to applying attendees who attend sessions and complete the required documentation. The goal of the conference is to continue providing information to all health care providers in the delivery of comprehensive immunization services for all age groups and to explore innovative strategies for improving immunization coverage rates through policy and program development.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	40.4	39.8	35	32	31
Annual Indicator	35.5	32.0	31.2	29.3	29.3
Numerator	3790	3402	3238	2984	2984
Denominator	106879	106293	103937	101974	101974
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	30	29	28	28	27

Notes - 2003

The 2003 denominator is based upon 2002 population estimate.

Notes - 2004

The 2004 data is provisional and based upon 2003 data.

a. Last Year's Accomplishments

In 2002, there were 3,238 births to teenagers aged 15-17, with the birth rate at 31.23 per 1,000 females age 15-17. In 2003, there were 2,984 births to teenagers aged 15-17, with the birth rate at 29.26 per 1,000. This represents the 8th consecutive year in which this figure had declined, surpassing the 2003 objective of 32 per 1000. In 2004, 12.5% of Family Planning clients, both male and female, were aged 15-17.

Direct Services
The OPH Family Planning Program (FPP) receives supplemental funding from Title V and

provides comprehensive medical, educational, nutritional, psychosocial, and reproductive health care services to adolescents. Since 2000, family planning clinics statewide have been instructed to facilitate adolescent access to services by prioritizing appointments offered for women 19 and younger. Efforts to increase access have been successful. In the calendar year 2004, visits by adolescent clients increased compared to the same period in the previous year. In 2004, a total of 5,691 patients aged 15-17 received direct services in family planning clinics across the state.
Statewide, three sites have special clinics reserved for adolescent clients. Two contract sites in New Orleans target services to adolescents. The Planned Parenthood of Louisiana (PPLA) contract with the FPP serves clients younger than 20, and the Adolescent Drop-In Clinic specializes in adolescent health care. Both sites have seen increases in the number of clients served.

Population-Based Services
Through the Adolescent Health Initiative (AHI), the FPP established partnerships with over 100 community organizations, schools, and churches, presented teen pregnancy prevention information to over 15,500 teens and health professionals. Family planning education materials and information packets, including 350 "Prevent Teen Pregnancy" information packets were distributed.

Infrastructure Building Services
AHI worked with several local and state agencies to provide technical assistance on teen pregnancy prevention mass media campaigns, presentations, and school health summits. Training activities were initiated to enhance service delivery to adolescent clients. The FPP's Training Manager focused attention on adolescent services in several training sessions, including prevention of sexual coercion and adolescent health services.

Quality Assurance for family planning services includes the use of youthful "mystery callers" to assess current clinic practices regarding services to teens. "Mystery calls" conducted between August and October 2004 indicated that adolescents can be seen for initial visits within 28 days in 60% of the FPP service sites statewide.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide comprehensive reproductive health care services to adolescents.	X			
2. Present and distribute education materials to teens and professionals.		X	X	
3. Provide technical assistance on teen pregnancy prevention mass media campaigns.			X	X
4. Provide training manual to clinic nurses to provide education on adolescent reproductive health issues.				X
5. Implement Quality Assurance activities, including mystery calls to clinics.				X
6. Make the Louisiana Teen Pregnancy Prevention Directory available online.			X	X
7. Train clinics to create a teen-friendly environment and increase teen utilization.				X
8. Contractswith local community-based organizations to conduct outreach to adolescents.		X	X	

9.				
10.				

b. Current Activities

Direct Services
The Family Planning Program continues to provide comprehensive reproductive health care services to adolescents. Because of budgetary constraints, the FPP had to terminate contracts with 19 providers in March 2005. This unavoidable change in the provision of direct services will affect the access to reproductive health services.

Enabling Services
The Family Planning Program provides outreach to young men and women in the New Orleans area through a contract with Women with a Vision, a local community based organization. A team of workers provides one-on-one and group reproductive health information. The outreach worker has made 5,027 high intensity contacts with African-American men and women aged 15-17.

Population Based Services
The Family Planning Adolescent Health Initiative staff maintains the Louisiana Teen Pregnancy Prevention Directory web site: http://oph.dhh.state.la.us/familyplanning/adhealth/index.html. The Directory allows adolescents and health professionals to stay informed about existing teen pregnancy prevention services in Louisiana.

Infrastructure Building Services
The FPP central office is paying close attention to the reduction in direct service contracts and it is exploring ways to overcome the deficit. The FPP plans to conduct a study named "The Mystery Caller Study" in near future in order to identify waiting time for a family planning clinic visit. The Mystery Caller Study has proven itself to be an effective means to identify the level of need for family planning services accurately. Based on the study results, the FPP will take necessary steps to meet the changed demand for family planning services.

Addressing teen pregnancy rates requires addressing the concerns of teens when entering into the health care system, while at the same time encouraging parental involvement in their children's reproductive health. To reduce teen pregnancy, the Family Planning Program has developed a training program to increase clinics' ability to create teen-friendly clinics and increase the number of adolescent-specific clinic sites in the areas of the state with the highest teen pregnancy rates. Training on these issues is available to clinic staff upon request. Targeting parental involvement and sexual coercion, the FPP has included several training sessions throughout the year.

Quality assurance of services to adolescents will be assessed in special Quality Assurance projects conducted on a regional basis.

c. Plan for the Coming Year

Objective: Decrease birth rate to 29 (per 1000) for teenagers aged 15 through 17 years.

Direct and Enabling Services
The FPP will continue to provide reproductive health care services to teens statewide. This will be reinforced by prioritizing adolescent scheduling in family planning clinics. Collaborative efforts will continue to be developed and strengthened with community based organizations working with adolescents.

Infrastructure Building Services
In an effort to increase the number of men and women under age 19 who access Family

Planning services, the FPP will conduct a statewide training program and provide technical assistance on attracting adolescents to clinics. The FPP will work toward increasing parental involvement in adolescent reproductive heath care.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	31	33	35	20	20
Annual Indicator	22.8	22.8	18.0	18.0	18.0
Numerator	317	317	157	157	157
Denominator	1390	1390	871	871	871
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	20	20	20	22	23

Notes - 2002

The State Oral Health Program has begun collecting sealant prevalence data on 3rd graders statewide. This preliminary data was used to tabulate the sealant prevalence rate for FY2002 because the Oral Health Program is confident that this data more accurately reflects the sealant status of this population than the data previously collected more than 5 years ago.

Notes - 2003

The State Oral Health Program has begun collecting sealant prevalence data on 3rd graders statewide, every 5 years. This data is used to tabulate the sealant prevalence rate for FY2003 because the Oral Health Program is confident that this data more accurately reflects the sealant status of this population than the data previously collected more than 5 years ago.

Notes - 2004

The State Oral Health Program has begun collecting sealant prevalence data on 3rd graders statewide, every 5 years. This data is used to tabulate the sealant prevalence rate for FY2004 because the Oral Health Program is confident that this data more accurately reflects the sealant status of this population than the data previously collected more than 5 years ago.

a. Last Year's Accomplishments

This measure was determined by an oral health screening of 871 children presenting 39 schools in 11 parishes in the state. The Oral Health Program trained 70 school nurses to conduct oral health screening on 3rd grade children to determine sealant utilization rates, untreated decay rates, caries experience rates, and treatment referral rates. The sealant utilization rate was 18%, down from 2000 annual indicator of 22.8%.

Direct Services
The Oral Health Program (OHP) in conjunction with David Raines Community Health Center in Shreveport provided a dental sealant program to 188 1st, 2nd and 6th grade children at Oil City Elementary School. One hundred and thirty-three (133) sealants were placed. The OHP and the Health Enrichment Network in Allen Parish screened 99 1st, 2nd and 6th graders at Oakdale Elementary and Middle Schools and 229 sealants were placed. The LSUHSC School of Dentistry sealant program screened 59 children in Orleans Parish and 112 sealants were placed; in Lafayette, 51 children were screened and and 105 sealants placed.

Enabling Services
The OHP continued to partner with the Bureau of Health Services Financing (Medicaid) to provide information to Medicaid eligible pregnant women on the Expanded Dental Services for Pregnant Women Program (EDSPW). The OHP worked with Medicaid
Outreach and provided brochures for insertion into the enrollment packets.

Population-Based Services
The OPH fluoridation program successfully fluoridated the communities of Lutcher and Oakdale. The city of Walker passed a resolution to begin community water fluoridation. Crowley signed a contract with the OPH to obtain the equipment for fluoridation. The OHP provided dental health education materials to numerous health fairs including the Indian Health Fair, and the Babies R Us health fair. Along with providing dental education to school nurses and teachers, the OHP provided dental health education to the Greater New Orleans Association for the Education of Young Children, the Louisiana Department of Education, Child and Adult Care Food Program (CACFP) Conference and child care providers through Agenda for Children. The OHP facilitated 200 dental health screenings on students from Woodson Middle School and linked the students for dental services at LSU School of Dentistry.

Infrastructure
The OHP provided dental health training on the EDSPW program to the Nurse Family Partnership nurses in Regions 1, 2, 8 and 9. In addition the OHP trained the obstetric nurses at Conway Hospital in Monroe and the obstetric nurses at Earl K. Long Hospital in Baton Rouge. The OHP provided dental health training to the OPH Regional Medical Directors Meeting and Women's Health Training Conference. The OHP attended the Louisiana chapter of the American College of Obstetricians and Gynecologists, convention and provided obstetricians with information on referring pregnant women for dental treatment and the EDSPW program.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide LSUHSC School of Dentistry sealant program for children in select Orleans Parish Public Schools.	X			
2. Provide LSUHSC Dental Hygiene sealant program for members of the Boys and Girls Clubs in Lafayette.	X			
3. Development of a sealant model for statewide application in Louisiana through the implementation of the HRSA sealant grant.			X	
4. Expansion of the sealant program through David Raines Health Center in Shreveport.	X			
5. Expansion of the sealant program through the Health Enrichment Network in Allen, Catahoula, Evangeline, Avoyelles and Concordia Parishes.	X			

6. Identify and apply for outside sources of funding for the expansion of the sealant program.				X
7. Identify community partners for sealant program.			X	
8.				
9.				
10.				

b. Current Activities

Direct Services
The OHP received a $65,000 HRSA grant to expand the dental sealant initiative. The OHP is working with the Health Enrichment Network to provide sealants to 1st and 2nd graders in 6 schools in Allen Parish and approximately 666 children. In Caddo Parish, the OHP partners with David Raines Community Health Center and provides sealants to 1st and 2nd graders at Timmons and Morningsport Schools. In East Feliciana Parish, the OHP partners with RKM school- based health center and screen 360 1st and 2nd graders for sealant placement at 3 schools. In DeSoto Parish, the OHP partners with the school nurse and provides the sealant program at six elementary schools and approximately 700 1st and 2nd graders will be screened. The LSUHSC School of Dentistry will screen 400 1st and 2nd graders for sealants from Osborne and Allen Schools in Orleans Parish and place sealants on the eligible children. The LSU School of Dentistry dental hygiene program in Lafayette continues a sealant program there.

Enabling Services
The OHP linked with Partners for Healthy Babies to provide information on the dental program for pregnant women on their website and on the Covering Kids and Families website and the Medicaid enrollment brochure. A pediatric dentistry resident was linked to the major WIC clinics in Louisiana to provide dental health information to these clinics. The OHP is working with Community Care to ensure that the case managers are referring children for dental examinations and treatment.

Population-Based Services
The OHP developed and aired a Public Service Announcement on the need for dental care during pregnancy; the PSA was aired in the six largest cities in Louisiana. A hotline number was established that provides information on the pregnant women's dental program 24 hours a day. The OHP provided information to the Regional Family Forum and the OPH Child Care Providers Training Conference. With the Maternity Program, OHP developed an educational packet (including information on the dental program for pregnant women) for obstetricians and their patients. The Fluoridation Program is currently working on fluoridation efforts in St. Bernard Parish and Walker; early efforts are underway to fluoridate Baton Rouge.

Infrastructure
The OHP provided a dental continuing education course on the relationship between periodontal disease and preterm birth to the Baton Rouge Dental Association and the Harold Wirth Dental Study Club. A course is also scheduled for the Region 9 dental association. The OHP hosted the 2nd State Oral Health Summit and developed a plan based on workgroup discussion. The OHP provided an update on the EDSPW at the OPH Regional Medical Directors Meeting. They performed an oral health needs assessment for the MCH Block Grant and helped create the state's priority needs for the next five years. The OHP continues to work with the Bureau of Health Services Financing (Medicaid) to monitor the EDSPW Program.

c. Plan for the Coming Year

Objective: Increase the percent of 6-9 year old children who have received protective sealants on at least one molar tooth to 20%.

Direct Services
The OHP will continue the expansion of the HRSA dental sealant program for 1st and 2nd graders to increase the number of children with dental sealants into 2-4 additional parishes. The program will provide dental screenings and sealant placement on the 1st molar teeth of eligible children. The sealant program will continue in Caddo, DeSoto, Allen and East Feliciana Parishes. The LSUHSC School of Dentistry sealant program will also continue to serve two Orleans Parish Schools and schools in Lafayette.

Enabling Services
The OHP will continue to partner with Medicaid outreach efforts to ensure that eligible pregnant women receive needed dental services through the EDSPW Program.

Population Based Services
The Fluoridation Program will continue efforts to fluoridate the cities of Baton Rouge and Walker as well as St. Bernard Parish through community education, oral health initiatives that support fluoridation, support of the Louisiana Dental Association and the local dental associations to increase the population in Louisiana that receive the benefits of community water fluoridation.

Infrastructure Services
The OHP will develop an advocacy policy agenda that will address securing adequate financial resources for dental services to ensure that dentists participate in the Medicaid dental program and provide adequate dental services to the maternal, child, adolescent and special needs population in the state. The OHP will also work with Louisiana Dental Association and the Louisiana State Board of Dentistry to expand the laws governing the practice of dental hygiene to include general supervision to increase the placement of sealants and other preventive measures. The OHP will work with Medicaid to improve the collection of reliable dental data for the EDSPW and child populations. The OHP will promote training for dentists who are willing to provide dental services to the special needs population to ensure that this population has access to dental services.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective	6	6	7	6.9	6.7
Annual Indicator	6.8	7.2	6.7	4.6	4.6
Numerator	68	71	65	45	45
Denominator	1002084	987585	976741	973127	976741
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**

Annual Performance Objective	6.7	6.6	6.5	6.5	6.5

Notes - 2002

2001 and 2002 data are provisional because current Census estimates used for the denominators are not yet available.

a. Last Year's Accomplishments

In 2002, 65 children aged 0-14 years were killed in motor vehicle crashes for a rate of 6.7 deaths/100,000 children, an improvement from the desired goal 7.0 deaths/100,000 children. Provisional data for 2003 shows that 45 children aged 0-14 were killed in motor vehicle crashes for a rate of 4.6 deaths/100,000 children, also an improvement from the desired goal of 6.9 deaths/100,000 children. The Maternal and Child Health (MCH) Program and the Bureau of EMS/Injury Research and Prevention Section (EMS/IRP) work toward reducing child vehicular deaths. MCH provides funding to Louisiana SAFE KIDS and funds the nine Regional Maternal and Child Health Injury Prevention (MCHIP) staff.

Population-Based Services
The MCHIP program and LA SAFE KIDS provided approximately 26 child restraint check-up events where caregivers got direct help installing their safety seat into their vehicle. Each Louisiana SAFE KIDS and Regional MCHIP Coordinator participated in at least one check-up event monthly, often in coordination with the Louisiana Passenger Safety Task Force.

The MCHIP Program and Louisiana SAFE KIDS offered child restraint technical assistance and educational outreach through health fairs, seminars, and workshops. Media outreach was carried out through newsletter submissions and television interviews. Community outreach was accomplished through dissemination of educational material such as brochures, pamphlets, and presentations to various groups such as childcare centers, Head Start facilities, health fairs, schools, and faith-based groups. In 2003, the MCHIP Coordinators gave 350 public presentations reaching approximately 10,000 people; provided professional education to approximately 5,522 teachers, nurses, and child care center staff; and conducted Risk Watch educational activities for children in 330 classrooms, reaching 10,000 children. Risk Watch is an unintentional injury program designed to teach children skills they need to be safe in areas that are the greatest risk of unintentional injuries.

Infrastructure Building Services
EMS/IRP Section provided staff support and mentored the nine regional MCHIP staff.

Louisiana SAFE KIDS analyzed data from community-based check-up events and compiled an annual report. Louisiana SAFE KIDS regularly supports legislative initiatives that support injury prevention.

The MCHIP Program reviewed existing injury prevention resources from National Highway Traffic and Safety Administration, American Academy of Pediatrics, Centers for Disease Control, Risk Watch, and The National SAFE KIDS Campaign. Information from these programs was tailored to fit the needs of agencies and communities that serve school-aged children in the state. The program disseminated information on wearing seat belts, pedestrian and traffic safety. It included fact sheets regarding data specific to motor vehicle crash injuries, prevention tips, and Louisiana laws.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			

	DHC	ES	PBS	IB
1. Provide Community Injury Prevention Coordinators in all nine regions of the state.			X	
2. Participate in the Louisiana Passenger Safety Task Force (at the state and regional levels).				X
3. Provide child restraint technical assistance (checkup events).			X	
4. Provide educational outreach through health fairs, seminars, and workshops.			X	
5. Conduct child mortality data analysis.				X
6. Provide media outreach through newsletters and interviews.			X	
7. Procure and distribute injury prevention resources such as car seats and educational materials.			X	X
8. Provide community outreach on child passenger safety through dissemination of educational material.			X	
9. Support legislative activities that support injury prevention.				X
10.				

b. Current Activities

Population-Based Services
From October 2003 -- March 2005, approximately 6 child restraint check-up events were organized throughout the state, with collaboration from the Louisiana Passenger Safety Task Force and Louisiana Highway Safety Commission. From 1998-2004, a total of 6,568 seats were checked. Ninety percent of the rear-facing seats were used incorrectly, 95% of the forward facing seats were used incorrectly, 50% of the belt-positioning booster seats were used incorrectly, 87% of the shield booster seats were used incorrectly, and 80% safety belt systems were misused.

Infrastructure Building Services
The MCH Program continues in its support of the Regional MCHIP Coordinators.

In addition to the State Child Death Review Panel for which the MCH Program provides staff support, local Child Death Review Panels have been established in all nine regions of the State through the OPH Regional staff and the Regional MCHIP Coordinators. The multi-disciplinary State and Local Child Death Review Panels review all unexpected deaths of children under the age of 15. Information collected by the Child Death Review Panel is used to determine preventive interventions that can decrease motor vehicle as well as other unexpected childhood deaths.

Louisiana SAFE KIDS developed information sheets explaining the new law relative to the use of appropriate child restraints by age and weight. This law became effective January 1, 2004.

c. Plan for the Coming Year

Objective: To decrease to 6.6 per 100,000 the rate of deaths to children aged 14 years and younger caused by motor vehicle crashes.

Population-Based Services
SAFE KIDS will continue to conduct and assist with monthly check-up events, while MCHIP staff will increase regional check-up events to twice monthly. Presentations to schools, daycare centers, and community-based organizations will be conducted twice monthly in each of the nine regions of the state.

Infrastructure Building Services
To facilitate this process, staff from EMS, IRP, MCHIP, and Louisiana SAFE KIDS will continue to conduct local injury prevention activities related to the establishment of community-wide child motor vehicle occupant injury programs with special emphasis on populations at high risk.

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	41	43	45	45	47
Annual Indicator	43.6	43.9	43.9	43.8	43.8
Numerator	28827.4	27871	27871	27632	27632
Denominator	66175	63482	63482	63112	63112
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	48.3	50	51.6	53.4	55.1

Notes - 2002
Louisiana PRAMS measures how many women surveyed breastfed at the hospital. Due to non-response, the 2000 LaPRAMS data set is representative of a portion of the LA births (66,175).

2001 and 2002 estimates are based on 2000 data from LaPRAMS.

Notes - 2003
Louisiana PRAMS measures how many women surveyed breastfed at the hospital. 2003 and 2004 estimates are based on 2002 data from LaPRAMS.

Notes - 2004
Louisiana PRAMS measures how many women surveyed breastfed at the hospital. 2003 and 2004 estimates are based on 2002 data from LaPRAMS.

a. Last Year's Accomplishments

Louisiana has experienced a slight decrease (43.9% in 2001 to 43.8% in 2003) in breastfeeding at hospital discharge.

Enabling Services
Two breastfeeding trainings were provided to WIC professionals, paraprofessionals and other community partners including Nurse Family Partnership nurses. A total of 315 participants attended the two trainings. Both trainings included local, national and international speakers. The offerings heightened breastfeeding awareness, encouragement and support of the breastfeeding participants. One of the two breastfeeding trainings was supported by a grant

received from the U.S. Department of Agriculture/Food and Nutrition Services, "Loving Support to Build a Breastfeeding Friendly Community." Breastfeeding mini-grants were made available to each region in the state to convert spaces to breastfeeding rooms, assist in providing breastfeeding trainings in the region and perform outreach to physicians in the region. Manual, electric and portable electric breast pumps were provided to the parish health units and other WIC sites, assisting over 3,000 breastfeeding women.

A toll-free 24-hour breastfeeding helpline, 1-800-251-2229, was made available in conjunction with the national Ad Council Breastfeeding Project and a combined effort between WIC, Louisiana Maternal and Child Health (MCH), Tulane University Xavier Center of Excellence in Women's Health, and Woman's Hospital in Baton Rouge.

Infrastructure Building Services
The Louisiana WIC Program received a national grant, "Using Loving Support to Build a Breastfeeding-Friendly Community". Community partners from 35 different entities attended a breastfeeding training opened statewide for the first time to non-WIC staff. Current issues and trends in breastfeeding were presented and a breastfeeding steering committee was formed. The steering committee developed a five-year strategic breastfeeding plan, which also included decreasing disparities largely seen in the African-American population and increasing breastfeeding initiation and duration rates. A report using LaPRAMS breastfeeding data from years 1998-2000 was presented at the National Maternal and Child Health Epidemiology Conference, highlighting the effect of the WIC program participation on breastfeeding practices among Louisiana mothers.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provision of hospital grade and portable electric breast pumps.		X		
2. Collection and analysis of WIC breastfeeding initiation and duration rates.				X
3. Implementation of breastfeeding policies and procedures including annual breastfeeding training for all clinic staff and monitoring of positive clinic environemnt that endorses breastfeeding.				X
4. Establishment of Regional Breastfeeding Coalitions with inclusion of community organizations.			X	X
5. Provision of a 24-hour breastfeeding helpline.			X	X
6. Utilization of culturally appropriate breastfeeding educational videos, handouts, and posters.		X	X	
7. Provision of breastfeeding classes for prenatal, postpartum and breastfeeding participants.				X
8. Provision of breastfeeding support and education materials for family members of breastfeeding clients.				X
9. Provision of breastfeeding media plan to ensure maximum exposure			X	X
10. Provision of mini grants to implement breastfeeding rooms, trainings and support kits to physicians.		X	X	X

b. Current Activities

Enabling Services
WIC sites continue to create clinic environments that endorse breastfeeding as the preferred

method of infant feeding. Sites provide culturally appropriate breastfeeding educational videos, handouts and posters to address racial and ethnic disparities. Structured breastfeeding classes are being offered to prenatal, postpartum and breastfeeding participants. Breastfeeding peer counselor training will be provided to the State Agency in Dallas, April 25-29, 2005, and piloted in two regions of the state beginning May 2005. Combining peer counseling with the on-going WIC breastfeeding promotion efforts has the potential to significantly impact breastfeeding rates among WIC participants, and, most significantly, increase the harder to achieve breastfeeding duration rates. WIC continues to provide manual, electric and personal electric breast pumps for assistance to breastfeeding participants.

Population Based Services
Regional Breastfeeding Coalitions are being established statewide, which include WIC, faith-based organizations, La Leche League, local hospitals, and other health care providers. Addressing racial and ethnic disparities and support is continuing at the community level with outreach activities being provided at faith-based organizations, daycare centers and head start programs, physician offices, community events such as March of Dimes WalkAmerica, and local venues such as the Louisiana Superdome.

Infrastructure Building Services
A new statewide resource guide was developed to include updated information on WIC Clinic Breastfeeding Coordinators, local La Leche League groups and leaders, hospitals and individuals statewide offering breastfeeding services. Breastfeeding information and links are included on National WIC Association Website.

c. Plan for the Coming Year

Enabling Services
WIC will begin work to establish and expand a breastfeeding peer-counseling program statewide. The United States Department of Agriculture/Food and Nutrition Services has provided the state with funds targeted for breastfeeding peer counseling. All WIC sites will continue to create clinic environments that endorse breastfeeding as the preferred method of infant feeding. Sites will continue to address large disparities seen among the different racial and ethnic groups by providing update and provide culturally appropriate breastfeeding educational videos, handouts and posters. Structured breastfeeding classes will continue to be offered to prenatal, postpartum and breastfeeding participants. Breastfeeding peer counselors will be expanded statewide as part of the on-going breastfeeding initiation and support effort. WIC will continue to provide manual, electric and personal electric breast pumps to participants as needed.

Population Based Services
Regional Breastfeeding Coalitions will continue to be established statewide until all nine regions have established its coalition. Breastfeeding awareness information and support will continue at the community level, including faith-based organizations, daycare and head start programs, physicians, other health care providers and community events.

Infrastructure Building Services
The new statewide resource guide will be updated on a continual basis to include information on WIC Clinic Breastfeeding Coordinators, local La Leche League groups and leaders, hospitals and individuals statewide offering breastfeeding services. Plans are in place to include breastfeeding information and links on the OPH Nutrition Services Website. As a part of the national grant, "Using Loving Support to Build a Breastfeeding-Friendly Community" WIC will partner with the Louisiana Maternal and Child Health Coalition to establish and implement a breastfeeding promotion initiative entitled The Gift. The Gift initiative will target all birthing hospitals in Louisiana with outreach, health promotion, and public/professional education and to enroll hospitals in a program, which assures breastfeeding-friendly policies regarding

lactation support and how infant formula is handled.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	60	65	70	85	93
Annual Indicator	55.6	70.3	82.4	92.6	95.3
Numerator	37970	39104	49865	59230	60968
Denominator	68273	55611	60494	63965	63991
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	95	98	100	100	100

a. Last Year's Accomplishments

The Hearing, Speech and Vision's (HSV) "Sound Start" Early Hearing Detection and Intervention (EHDI) program has made universal newborn hearing screening a priority. The goal of this program is to increase the proportion of newborns that are screened for hearing loss by 1month of age, have audiological evaluation by 3 months of age, and receive appropriate early intervention services by 6 months of age. By reaching these goals, the program seeks to reduce the morbidity, development delay and educational delay associated with hearing loss. During 2003, the program continued to exceed the objective of 85% of newborns screened for hearing loss, with 92.6% of newborns (59,230 out of 63,965) screened.

Direct Services
Follow-up services were provided by HSV audiologists to provide audiological evaluations for children who refer and cannot be evaluated in the private sector due to lack of insurance or no access to local community services. Audiologists with the HSV program provided 698 audiological evaluations to infants across the state. Direct newborn hearing screening services are mandated by law and provided by hospital-based screening programs at all birthing hospitals in the state.

Enabling Services
The program widely distributed pamphlets for parents. Pamphlets focused on information for new and expectant parents and parents of newborns who refer for further hearing testing. The program also disseminated information to pediatricians statewide to educate and inform them of newborn hearing screening and recommended practices for follow-up. The HSV program expanded support to parents through increasing to full time the services of a statewide parent consultant. The Parent consultant for HSV provided input on state level policy and system issues as well as individual parent support.

Population-Based Services
This program is a population-based program that screened all babies born in Louisiana for hearing loss before hospital discharge. State law mandates EHDI, and is accomplished at all 67 Louisiana birthing hospitals. Hospitals are required to report screening results to the EHDI program.

Infrastructure Building Services
The program provided infrastructure building services to birthing hospitals to allow hospitals to accomplish this Performance Measure. Sound Start personnel provided quarterly and annual data reports to hospitals for monitoring purposes. Staff also provided training and technical support to hospital personnel for testing, reporting data, and linking families to follow-up services, utilizing the standards of legal requirements and recommended procedures developed in 2002. The program also improved reports available in the database to allow for more effective monitoring and evaluation. Two regions in the state were targeted for system building activities. Models of efficient and effective systems were developed for replication in other areas of the state.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Improve data monitoring and tracking systems for Sound Start program.				X
2. Provide training and standards for early hearing detection and intervention personnel.				X
3. Provide parent education, outreach and support, including producing pamphlets in another language.		X	X	
4. Follow-up and tracking systems for children suspected of hearing loss.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Direct Services
Follow-up services continue to be provided by HSV audiologists in audiology clinics throughout the state, where there is no access to services through other facilities. Direct screening services continue to be provided by hospital-based screening programs at all birthing hospitals in the state.

Enabling Services
In addition to providing parent brochures about newborn hearing screening to hospitals, for dissemination to new parents, the Sound Start staff has completed brochures designed for families of babies who do not pass the hospital screening and need further testing and general informational brochures for distribution in prenatal classes. Focus groups have been held in 2 regions of the state. The program is analyzing information from the focus groups prior to completing the other regions. HSV is collecting information on the opinions of these families

and on the barriers and successes they face in getting services for their children. Additionally, the HSV parent consultant is addressing these issues.

Population-Based Services
To supplement universal hearing screening for newborns performed at each of the 67 birthing hospitals in the state, Sound Start is working on developing an improved Tracking and Follow-up System. This system will track babies who fail the newborn hearing screening and will ensure that these newborns get follow-up audiological evaluation and, if identified with a hearing loss, early intervention services.

Infrastructure Building Services
Sound Start personnel continue to provide quarterly and annual data reports to hospitals for monitoring purposes as well as training and technical support to hospital personnel for testing, reporting data and linking families to follow-up services. The lowest performing hospitals are targeted, based on the percentage of newborns screened for hearing loss during birth admission and the percentage of newborns referred for further testing. During the current fiscal year, the program is developing standards for pediatric audiological evaluation (Pediatric Audiology Guidelines). The document "Guidelines for Early Intervention Programs: Serving Infants and Toddlers Who Are Deaf or Hard of Hearing and Their Families" has been completed and approved by the statewide Advisory Council. The program continues to update and improve its Sound Start database to allow for more effective monitoring and evaluation of screening programs. Regional Task Forces, comprised of all stakeholders, meet at least annually in each region of the state to address local issues and improve service delivery.

A survey of hospital screening supervisors was completed in 2003. Based on this survey, training for the supervisors is ongoing through the regional task force meetings throughout the year. In this manner, training is targeted to issues based on the needs specific to each region, and has been found to be the most effective training system.

c. Plan for the Coming Year

Objective: To increase to 98% the proportion of newborns who are screened for hearing loss before hospital discharge.

Direct Services
Screening and follow-up services will continue to be provided by the HSV audiologists where there is no access to local community services. The HSV program audiologists will continue to work to establish partnerships in the private sector throughout the state.

Enabling Services
The Sound Start program will extend the distribution of all pamphlets for parents. Pamphlets focus on information for new parents, expectant parents and parents of newborns who refer for further testing. Additionally, these pamphlets will be developed in at least one other language (Spanish). The Sound Start program will also continue to disseminate informational pamphlets to pediatricians to educate and inform them about newborn hearing screening. The program will continue Parent Support groups for families of children with hearing loss and will foster establishing a statewide organization for families of children who are deaf or hard of hearing. Additionally, a parent resource guide for issues related to hearing loss will be developed and made available to parents of newly diagnosed children.

Population-Based Services
Birthing hospitals in the state will continue to strive to meet the goal of universal screening -- that every baby born in Louisiana will be screened for hearing loss before 1 month of age. The program will continue to collect data on newborn hearing screening and a follow-up coordinator will implement a follow-up system to ensure that all infants who do not pass a hearing

screening receive appropriate follow-up services. The HSV program will acquire a database system to improve tracking and monitoring for follow-up, based upon availability of funding.

Infrastructure Building Services
Monitoring activities, training, and technical support services are ongoing. Monitoring and evaluation of statewide Sound Start program will occur monthly to continuously improve services and meet all goals. Educational training will be provided to audiologists and physicians throughout the year, especially through the regional task force system. HSV and Louisiana's Part C Early Intervention program (EarlySteps) will work to accomplish a closer coordination between newborn hearing screening and early intervention services to assure that Louisiana improves follow-up rates and to assure that children receive needed services by 6 months of age.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	24.5	15	15	14	11
Annual Indicator	16.4	13.3	12.4	15.4	15.4
Numerator	197589	174478	152790	194293	194293
Denominator	1201454	1310692	1234917	1263241	1263241
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	13	12	11	10	9

Notes - 2002

FY 2001 estimates are from the AAP, Children's Health Insurance Status Medicaid/SCHIP Eligibility and Enrollment Report 2001 report. Data not yet available for FY 2002.

Notes - 2003

FY 2003 estimates are from the AAP, Children's Health Insurance Status Medicaid/SCHIP Eligibility and Enrollment Report 2003 report. .

Notes - 2004

FY 2004 estimates are from the AAP, Children's Health Insurance Status Medicaid/SCHIP Eligibility and Enrollment Report 2003 report. Data is not yet available for 2004.

a. Last Year's Accomplishments

The percentage of uninsured children from birth to 19 years increased from 12.4% to 15.4% in 2003, above our 2003 target of 14%. This is an estimate from the American Academy of Pediatrics' analysis of the Census Current Population Survey, which has been used for this measure from 1997 through 2002. This is in contrast to the Louisiana Health Insurance Survey

conducted by the Louisiana Department of Health and Hospitals in 2003 which found that the percent of uninsured children was 11% and SLAITS Child Health Survey of children done in 2003 which found the 8% of children less that 18 years were without health insurance.

It is difficult to understand the increase since the number of uninsured children has decreased markedly due to the efforts of the Louisiana State Child Health Insurance Program, LaCHIP, which has expanded income eligibility in the Medicaid Program up to 200% of Federal Poverty Level for children up to 19 years of age. The number of children from birth to 19 years receiving Medicaid benefits through the regular Medicaid and the LaCHIP Medicaid expansion has increased from 319,156 in October 1999 to 643,834 in September 2004.

Enabling Services
All clients attending one of the 70 Public Health Units (PHU) for WIC or other Child Health services are screened for income eligibility for LaCHIP/Medicaid. Clients who are income eligible and are currently uninsured are provided information on LaCHIP/Medicaid and an application. In subsequent visits, LaCHIP/Medicaid eligibility is determined and further information and assistance is offered to those who are still eligible but remain uninsured. In addition, the Office of Public Health (OPH) screens for income eligibility for pregnant women who come to PHUs for WIC or other health services and provides them with applications and referral information.

Population-Based Services
The MCH Program has continued to work with the Robert Wood Johnson (RWJ) funded Agenda for Children's Covering Kids and Families Initiative in their outreach efforts. The goals of this Program are to 1) coordinate and conduct outreach, 2) simplify enrollment and renewal processes, and 3) coordinate health coverage programs. The MCH Program Director has served on the Advisory Board for the Covering Kids and Families Initiative.

Infrastructure Building Services
The MCH Program maintains a working relationship with the State Medicaid and LaCHIP staff and remains a resource to provide technical information and assistance. The MCH Program also works with Medicaid staff in providing updated information to the 70 OPH clinics throughout the State.

With a change in the Governor of the State in 2004, a Health Summit was held in March 2004. MCH staff participated in the summit and continues to participate in the State Health Care Reform Panel and Regional Consortiums to address reform efforts at the State and local levels. OPH Regional Staff are involved with the regional consortium.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Eligibility screening for Medicaid/LaCHIP for all infants, children, & pregnant women seen in OPH.	X			
2. Provide Medicaid eligible clients with information on Medicaid and how to apply.	X			
3. Technical assistance and support to Agenda for Children in their outreach efforts.			X	X
4. Technical assistance to the LaCHIP and Medicaid Programs for outreach and enrollment.				X
5. Monitoring of and participation in Health Care Reform activities related				

to health care coverage and access to care				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

After the results of the surveys conducted in 2003 highlighted regional differences in rates of uninsured children, the Medicaid program intensified it outreach efforts in those areas. Although there has not been a recent study on the differences of uninsured children by region in the state, the increasing number of children enrolled in the program may indicate success of those efforts. There has been an increase of approximately 15,000 children enrolled in the Medicaid Program from 643,834 in September 2004 to 659,575 in March 2005.

Enabling Services
The OPH clinics continue screening pregnant women, infants and children who they see for WIC or other services for income eligibility for LaCHIP/Medicaid. Those who are found income eligible are provided application forms and/or given referral information for application for these programs.

Population-Based Services
The MCH Program continues to work with Agenda for Children's Covering Kids and Families Initiative in support of their outreach activities through the Statewide as well as local coalitions. There are currently 6 regional coalitions located throughout the state. The work of the regional coalitions should help to decrease the regional differences in rates of uninsured children.

Infrastructure Building Services
The MCH Program remains a resource to provide technical information and assistance to the LaCHIP and Medicaid Programs, in addition to working with Medicaid staff in providing updated information to the 70 OPH clinics throughout the State.

c. Plan for the Coming Year

Objective: Decrease the percentage of uninsured children to less than 12%.

Enabling Services
We will continue screening and referral of those uninsured infants, children and adolescents who are eligible for LaCHIP/Medicaid services as well as pregnant women to LaMOMS.

Population-Based Services
The MCH Program will continue to work with Agenda for Children in their outreach efforts.

Infrastructure Building Services
The MCH Program will continue to work with the Medicaid Program in providing technical assistance and information, particularly in addressing issues of access to service. MCH Program staff will also monitor and participate in the State Health Care Reform Initiative related to health care coverage and access to care.

Performance Measure 14: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	75	75	75	75	80
Annual Indicator	73.9	70.7	78.0	85.8	85.8
Numerator	430073	480823	547454	617784	617784
Denominator	582192	680244	701643	719640	719640
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	85	88	90	90	90

Notes - 2002

FY 2001 numerator is from Louisiana Medicaid Program's Annual Report 2000/2001, - number of children under 19 who received a service. The denominator is from the American Academy of Pediatrics' Children's Health Insurance Status Medicaid/SCHIP Eligibility and Enrollment Report 2001 - estimate of the number of children through 18 years eligible for the Medicaid/State Child Health Insurance Program.

FY 2002 estimate is based on 2001 data because data is not yet available for FY 2002.

Notes - 2003

FY 2002 numerator is from Louisiana Medicaid Program's Annual Report 2001/2002, - number of children under 19 who received a service. The denominator is from the American Academy of Pediatrics' Children's Health Insurance Status Medicaid/SCHIP Eligibility and Enrollment Report 2002 - estimate of the number of children through 18 years eligible for the Medicaid/State Child Health Insurance Program.

a. Last Year's Accomplishments

An estimated 85.8% of potentially Medicaid eligible children actually received a Medicaid-paid for service in 2003. This is an increase from 78% in 2002 even with an increase of 17,997 in the potentially eligible from 701,643 to 719,640. The actual number of recipients of services increased from 547,454 to 617,784. The increase in the number of potentially eligible is due to increasing income eligibility to 200% of Federal Poverty Level under CHIP that occurred on January 1, 2001 and completion of the statewide implementation of Community Care, Louisiana's Primary Care Case Management for Medicaid clients by the end of December 2003. For infants, children and adolescents, this includes assuring each receives EPSDT screening services.

Provider availability was assessed through a Needs Assessment conducted by the Children's Special Health Services (CSHS) Program. The Needs Assessment found that 603 or 52% of the 1159 Primary Care Providers surveyed were open to new Medicaid clients and 13% were at their maximum. There were differences by the State Regions with highs in Lafayette (64% open and 10% at max), North Shore (59% open and 4% at max), and New Orleans (56% open and 12% at max). Regions at the low end were the Lake Charles (30% open and 24% at max),

Houma/Thibodaux (36% open and 8% at max), and the Shreveport (33% open and 20% at max).

Direct and Enabling Services
The MCH Program provides comprehensive preventive child health services in the parish health units (PHU) to children whose families are uninsured or who lack access to a primary care provider. All children receiving services are screened for Medicaid/LaCHIP eligibility and are provided applications for enrollment if found eligible. MCH has a contract with Medicaid to conduct EPSDT screening in PHUs particularly in areas of the state where there is limited provider availability. In some of the Community Care parishes, PHUs contract with Community Care Providers to perform these EPSDT services. In State Fiscal Year 2004, 2,979 screening visits for infants and children were conducted through the PHUs. MCH has also supported community based child health programs that provide pediatric primary care.

Population-Based Services
The MCH Program Director was on the Advisory Board for the Agenda for Children's Covering Kids and Families Project. The goals of this Program are to: 1) coordinate and conduct outreach 2) simplify enrollment and renewal processes, and 3) coordinate health coverage programs. As an Advisory Board Member, she has had input into the outreach efforts of this program.

Infrastructure Building Services
The MCH Program has worked with the Regional Offices and PHUs in dissemination of information related to Community Care. A Needs Assessment was conducted by the CSHS Program, providing information on the current capacity of primary and specialty health care providers to care for uninsured and Medicaid enrolled children as well as children with special health care needs.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide EPSDT screening services to Medicaid children who are seen in the OPH clinics.	X			
2. Eligibility screening for Medicaid/LaCHIP for all infants, children, & pregnant women seen in OPH.		X		
3. Provide Medicaid eligible clients with information on Medicaid and how to apply.		X		
4. Work with local and regional public health staff to implement Community Care.		X		X
5. Establish and implement a pilot program for home visiting program for new low income mothers to increase knowledge about and utilization of Medicaid-paid services.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Direct Services
The Office of Public Health continues to provide screening services to low income child health patients who do not have a private health care provider through the PHUs. In some areas of the state, screening services for Medicaid infants and children are being provided in the PHUs through contracts with Community Care physicians. MCH medical and nursing consultants are working with the field to update the child health protocols related to developmental screening, provide training to parish public health unit staff, and monitor CQI performance measures and statistics.

Enabling Services
The Office of Public Health continues to screen for income eligibility for the Medicaid and LaCHIP Programs and provides information and application materials to those found eligible. The Child Health Program staff is in the process of developing a pilot program of providing comprehensive home visits to low income mothers in the immediate post-partum period for a health, environmental, and psychosocial assessment, education targeted to needs, and reinforcement of information related to the need for routine health care and how to access Medicaid services. One of the desired outcomes of this program will be increased understanding and utilization of preventive services by Medicaid enrolled infants and children.

Population-Based Services
The MCH Program continues to support the efforts of Agenda for Children's Covering Kids and Families Project.

Infrastructure Building Services
With the shift in direct services in most parts of the State to the private sector, the MCH Program is continuing to work with Regional and PHU staff in assuring that clients receive needed services from private health providers. The MCH Program also works with Medicaid and Community Care Administrative staff in addressing issues that arise in clients receiving services.
As a part of the Early Childhood Comprehensive Systems Building Initiative, a State Plan for the implementation of such a comprehensive system is in the process of being completed. Access to health care and a medical home for all children will be a part of that plan for young children.

The MCH Child Health Medical Director will continue to work with the State EPSDT (KIDMED) Program, the Medicaid Program, and the Louisiana Chapter of the American Academy of Pediatrics Executive Committee to address issues and concerns related to the State's Medicaid and Community Care Programs and access and availability of care for all children.

c. Plan for the Coming Year

Objective: Increase to 88% the percent of potentially Medicaid-eligible children have received a service paid by the Medicaid Program.

Direct Services
The MCH Program will continue to support the provision of comprehensive preventive health services in the PHUs for uninsured clients as well as those who have limited access to such services. In Community Care Parishes, screening services for Medicaid infants and children will continue to be provided in the PHUs through contracts with Community Care Providers.

Enabling Services
The MCH Program will continue to screen for income eligibility for the Medicaid and LaCHIP Programs and provide information and application materials to those found eligible. The pilot project for home assessment for low income mothers in the postpartum period will be implemented and evaluated.

Population-Based Services
The MCH Program will continue to support outreach efforts for the Medicaid/LaCHIP Programs through working with Agenda for Children's Covering Kids and Families Project.

Infrastructure Building Services
The MCH Program will continue to work with Regional and PHU staff in addressing issues related to the implementation of Community Care. MCH medical and nursing consultants will work with the field to update maternity and child health protocols and manuals, provide training to parish public health unit staff, and monitor CQI performance measures and statistics. The MCH Child Health Medical Director will continue to work with the State EPSDT (KIDMED) Program, the Medicaid Program, and the Louisiana Chapter of the American Academy of Pediatrics Executive Committee to address issues and concerns related to the State's Medicaid and Community Care Programs and access and availability of care for all children.

Performance Measure 15: *The percent of very low birth weight infants among all live births.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	1.82	1.8	1.8	1.8	2.2
Annual Indicator	2.4	2.3	2.1	2.2	2.2
Numerator	1614	1508	1328	1400	1400
Denominator	67843	65183	64743	64677	64677
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	2.2	2.2	2.2	2.2	2.2

Notes - 2002
Data is calendar year.

Notes - 2003
Data is for calendar year.

Notes - 2004
Data is for calendar year. 2004 data is provisional.

a. Last Year's Accomplishments

The very low birth weight (VLBW) rate for 2003 was 2.2%, 2.1% for 2002 and 2.3% for 2001.

Direct Services
MCH provided prenatal services through 70 parish health units (PHU) including 50,689 maternity visits for comprehensive prenatal care, pregnancy testing, and/or WIC related and

prenatal education, in 2004. Ten contract sites offered services, in areas of high need with limited provider resources.

Enabling Services
The Louisiana Risk Assessment (LRA) was piloted in 6 regions, assessing medical, mental, and social factors that may result in preterm birth along with referral for needed services.

MCH contracted with Medical Center of Louisiana-New Orleans (MCLNO) to address substance abuse in pregnancy. Using the 4Ps Plus tool, 1423 women were screened. Urine toxicology screens were performed on all initial prenatal clients: There were 15.6% positive for THC, 3.6% for cocaine and 1.3% for opiates. There were 173 perinatal clients enrolled in treatment. Of these, 51.2% also had mental health diagnosis or symptoms.

MCH targeted the infant mortality problem and low birth weight in all regions. Interventions addressed outreach, case management, Nurse Family Partnership (NFP), Fetal Infant Mortality Reviews (FIMR), appropriate weight gain, smoking cessation, oral health, prenatal care access, and the racial disparity in these issues. MCH addressed gaps in smoking cessation services for perinatal populations through a contract with the American Cancer Society (ACS). The ACS program trained 20 facilities,including19 public and 99 private providers. The program screened approximately 5500 pregnant women, and counseled approximately 1000 pregnant smokers with a 7.1% smoking cessation rate. MCH and Medicaid began a dental program, targeting pregnant women with signs of periodontal disease. Information is given to every newly enrolled Medicaid pregnant woman. MCH provided packets and presentations to providers on the link between periodontal disease and VLBW births.

Population-Based Services
The Partners for Healthy Babies (PHB) social marketing campaign focused on proper weight gain in pregnancy, oral health and other low birth weight risk factors.

Infrastructure Building Services
Foundation work on the Louisiana Infant Mortality Reduction Initiative (IMRI) was completed. This is a regionally based, state directed effort to address high infant mortality rate, with low birth weight being a leading cause. The 2nd annual Epidemiology and IMRI Meeting was held in November 2003, addressing MCH indicators, Perinatal Periods of Risk, and presentations of successful programs in states, and regions of Louisiana. Dr. Charles Mahan presented the Florida experience in infant mortality reduction efforts and Dr. William Sappenfield presented the CDC perspective. All regions participated. PRAMS surveillance continued and the MCH Databook was distributed to stakeholders statewide.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide prenatal care for women with no health insurance coverage or access to private medical care.	X			
2. Provide nurse home visiting program (Nurse Family Partnership) for first-time mothers.		X		
3. Provide Smoking cessation programs for pregnant women using the Make Yours a Fresh Start Family model.		X		
4. Support Partners for Healthy Babies public information campaign for prenatal health.			X	
5. Provide Fetal and Infant Mortality Reduction Initiative in each region of				

Louisiana.		X		X
6. Provide Pregnancy Risk Assessment Monitoring System (PRAMS) surveillance system.				X
7. Support prevention of periodontal disease in pregnant women, through education and treatment.		X	X	
8. Provide substance abuse screening and treatment services.		X		
9.				
10.				

b. Current Activities

Direct Services and Enabling Services
The LRA is utilized in 6 regions. Through April 2005, the Monroe MCH-OAD program screened 769 women for substance abuse, referred 47 for further assessment, and 16 for intensive outpatient treatment. Referrals are ongoing for smoking cessation and mental health services. We are collaborating with OAD to expand a similar program statewide.

OAD has received Access to Recovery funds, providing a voucher for treatment, with pregnant women as one of the target groups. Tobacco screening and cessation programs are ongoing in conjunction with Louisiana Public Health Institute (LPHI) and the Louisiana Tobacco Control Program. Louisiana is one of the selected states in the Tobacco Cessation Action Learning Lab. Medicaid coverage of dental services to pregnant women continued.

Population-Based Services
The Partners for Healthy Babies Campaign is ongoing. A prenatal care fair was held in Region 8. Final steps are being taken to contract with a new helpline operator. PHB promotes the LaMOMS Medicaid program, early prenatal care, oral health services, and proper weight gain in pregnancy.

Infrastructure Building Services
IMRI is coordinating agencies in each region to assess resources, analyze data, and coordinate more effective interventions. Regional IMRI coordinators are establishing infrastructure for assessment, policy development, and implementation issues. Contracts are in place in all regions, to establish a FIMR panel, a lead coordinator, outreach, and NFP services. The regional IMRI groups were instrumental in the local portion of the 2005 MCH Needs Assessment and Strategic Planning process. The Maternity Medical Director and Nurse Consultant have performed "MCH detailing" visits in 4 regions.

MCH continues to provide statewide training on the relationship between periodontal disease and premature births and the Medicaid dental coverage, via education and direct mailing to physicians, and information at the state ACOG meetings. MCH is working with Medicaid to develop the Family Planning waiver.

A 3rd annual Perinatal Epidemiology & IMRI Meeting was held in November 2004, addressing MCH indicators, Perinatal Periods of Risk, 2005 needs assessment, logic models, strategic planning, and presentations of other successful programs. Dr. Michael Lu presented and facilitated small group discussions. All regions participated.

Louisiana is in the CDC led State Infant Mortality (SIM) Collaborative, exploring data collection, data analysis, and interventions to address infant mortality. A Pregnancy Associated Mortality Review (PAMR) process is being established. The Maternity Medical Director now receives death certificates and the review process will begin once all are available. The Louisiana Folic Acid Council is planning an expansion of its mission to promote improved pre- and interconceptional care. MCH partially funds the Council and is working to coordinate the

mission change.

c. Plan for the Coming Year

Objective: The percent of very low birth weight infants will be maintained at 2.2%.

Direct and Enabling Services
Direct services will continue in areas with prenatal care access problems. Data analysis will be conducted to identify regions with poorest outcome markers and high racial disparity to enhance services to those areas. The NFP Program will continue in 28 parishes.

The LRA tool will be available in all regions of the state. An evaluation method of LRA will be developed. MCH will work with OAD to provide statewide screening for substance abuse and mental health utilizing a validated screening tool.

Population-Based Services
The PHB public information campaign will continue. Plans include expansion of the website as a forum for the FIMR and NFP, including a list-serv and calendar of activities. We will continue to collaborate with the LPHI to air multimedia campaigns for perinatal smoking cessation.

Infrastructure Building Services
The Louisiana IMRI will expand its efforts to create Regional Forums that will serve as umbrella organizations within the community for MCH issues. The Maternity Medical Director and Nurse Consultant will expand the statewide direct detailing visits to providers and hospitals of high-risk obstetrical populations, providing strategies to prevent preterm births. IMRI will begin to develop an ongoing article-based CME offering to obstetrical providers, focusing on prematurity issues. Training in cultural awareness and proficiency will be conducted for perinatal providers. Disparity in outcomes will continue to be evaluated and addressed in program planning.

The 4th Epidemiology & IMRI statewide meeting is scheduled for October 2005. This meeting will continue to focus on prematurity and the further development of Regional Forums. PRAMS surveillance and analysis will continue. MCH will organize an interstate committee to develop recommendations for effective interventions on proper prenatal weight gain projects.

MCH will work with Medicaid for the use of quality outcome measures within the MCH population. Progress will continue for a Medicaid waiver to expand eligibility for Family Planning services for women of reproductive age.

The Pregnancy Associated Mortality Review (PAMR) group will be formed and review all maternal deaths. MCH will work with the Louisiana Folic Acid Council to expand their role in education on pre- and interconceptional care and to increase education on interconceptional care to high risk women. This will done through collaboration with the Vital Records' mailing of birth certificates, Early Steps case management, and the Birth Defects Advisory Council.

Steps will begin to establish a model curriculum for medical school and Ob/Gyn residencies on the role of public health issues in pregnancy outcomes. Regional IMRI will work on new collaboration with faith-based, business, professional and minority communities, and their roles in infant mortality reduction.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	11.03	10.75	8	7.8	7.6
Annual Indicator	8.2	9.2	7.6	9.2	9.2
Numerator	30	33	27	32	32
Denominator	365945	359083	353339	347200	347200
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	8.8	8.6	8.4	8.2	8

Notes - 2002

Data is calendar year.

Notes - 2003

Data is for calendar year.

Notes - 2004

Data is based upon 2003 calendar year data.

a. Last Year's Accomplishments

Adolescent suicide is the 3rd leading cause of death for adolescents nationally and in Louisiana. In 2003, the rate (per 100,000) of suicide deaths among youths aged 15-19 was 9.2. This is an increase from 7.6 in 2002. The data reported for 2004 is provisional.

Direct Services

The Adolescent School Health Initiative (ASHI) Program, a statewide network of School-Based Health Centers (SBHCs), collaborated with the State Office of Mental Health (OMH) to provide mental health counseling and referrals. In 2002-2003, 2 of the SBHCs had OMH staff working on site. Each SBHC has a formal suicide prevention protocol in place. Also a statewide uniform encounter form based on ICD-9 codes was implemented in the 1997-98 school year

Infrastructure Building Services

In January 2001, the Adolescent Health Initiative (AHI), in conjunction with the ASHI Program and several other agencies, formed the Louisiana Youth Suicide Prevention Task Force. A statewide suicide prevention plan was formulated, with the priorities of the plan focusing on suicide prevention for Louisiana youth through the training of gatekeepers, awareness campaigns, and advocacy efforts. At the end of 2002, the first series of Gatekeeper Trainings reached 400 schools, health and community professionals in the state. In February 2003, the Louisiana Board of Secondary Education (BESE) unanimiously passed the first suicide prevention school plan. In 2004, Gatekeeper Trainings and multi-parish planning summits reached 760 schools, health and community professionals in all nine regions of the state. The Louisiana Suicide Prevention Week in May 2004 included the 1st Louisiana Walk Against Suicide, multi-parish planning summits, the Suicide Prevention Day at the Capitol and statewide press release. The Task Force facilitated the governor's proclamation of September 19-25, 2004 as the 4TH Yellow Ribbon Youth Suicide Prevention Week with activities

conducted to raise awareness such as the distribution of Yellow Ribbon packets to schools, a statewide essay and poster contest, an awards luncheon, numerous media reports and a picture with the Louisiana Governor.

Also as apart of the Task Force efforts, the first college Yellow Ribbon Chapter was formed on the campus of Southeastern University in Hammond, Louisiana. Presently there are 60 college students in this chapter. This chapter and the State Task Force presented a program on Suicide Prevention at the Louisiana Association of College and University Student Personnel Administrators (LA CUSPA) meeting in August of 2004. Additionally, the task force has provided technical assistance and expertise for the CDC/ Suicide Prevention Resource Center/ Children's Safety Network - Federal Region VI & IV's Suicide Prevention Conference that occurred December 3-5, 2003, by facilitating sessions, organizing Tulane student volunteers and presenting the Louisiana Strategic Plan to Prevent Youth Suicide.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. School-Based Health Centers provide mental health counseling and referrals.	X			
2. Coordination of Louisiana Youth Suicide Prevention Task Force.				X
3. Training of school, health and other community professionals on youth suicide prevention.			X	X
4. Facilitation and coordination of youth suicide awareness activities.			X	X
5. Participation in mandatory youth suicide prevention program in public schools.			X	X
6. Coordination of 1st Yellow Ribbon Chapters onto Louisiana colleges and universities.			X	X
7. Training of identified regional leaders on the two-day ASIST Gatekeeper Curriculum.				X
8.				
9.				
10.				

b. Current Activities

Direct Services
The Adolescent School Health Initiative Program continues to provide direct mental health counseling and referral to Louisiana's youth. There are 53 state-funded SBHCs, 1 federally funded SBHC, and a SBHC funded by the Rapides Foundation in the state, providing access to nearly 50,000 students. Mental health concerns are among the top 3 most common reasons for visits to SBHCs in both urban and rural areas of Louisiana. The centers continue to collaborate with the State Office of Mental Health to provide mental health counseling and a mechanism for referral, as well as to obtain technical assistance and quality assurance evaluations.

Infrastructure Building Services
The Louisiana Youth Suicide Prevention Task Force, chaired by the Adolescent Health Initiative will continue to administer monthly planning meetings of the 25-member state task force, to attend quarterly meetings of the Department of Education's School Subcommittee on Youth Suicide, and to serve as a statewide resource on youth suicide prevention to various community--based agencies, faith-based institutions and youth serving agencies. The task

force is presently applying for the SAMSHA's State/Tribal Youth Suicide Prevention Grant Program in order to implement more early intervention and prevention strategies in Louisiana schools, educational institutions, juvenile justice systems, substance abuse programs, mental health programs, foster care systems and other child and youth support organizations.

The Task Force continues to conduct a series of Gatekeeper Trainings in order to reach school personnel in all 9 regions of the state. Also the task force is continuing to conduct multi-parish planning summits to mobilize community leadership around the topic of youth suicide prevention. The last multi-parish planning summit that the task force sponsored in conjunction with the Lafayette area Mental Health Association occurred in April 2005 in the Lafayette area. At this summit nearly 70 school, health, and mental health professionals, parents, clergy, youth program directors and survivors were in attendance.

Lastly, the task force has formed a subcommittee known as C.A.U.S.E. (College And University Suicide Eradication). The first C.A.U.S.E meeting occurred in January 2005. This group will meet six times a year to develop strategic activities to incorporate Yellow Ribbon Youth Suicide Prevention Chapters into Louisiana colleges and universities. The task force's goal is to have no less than three Yellow Ribbon Chapters organized and implemented into area universities.

c. Plan for the Coming Year

Objective: Decrease the rate of suicide deaths among youths 15-19 to 8.6 (per 100,000).

Direct Services
Through the ASHI Program, the SBHCs will continue to collaborate with OMH to provide mental health counseling and referral. ASHI has requested additional funding from the State Legislature to plan eight new SBHCs in 2004-2005, which would become operational in 2006.

The task force requested additional funding from SAMSHA 's State/Tribal Youth Suicide Prevention Grant Program to increase the state's capacity to build on the already existing foundation of prior suicide prevention efforts and to expand prevention efforts into more areas of the state.

Infrastructure Building Services
The Louisiana Youth Suicide Prevention Task Force, chaired by the Adolescent Health Initiative will work collaboratively with the Department of Education's School Subcommittee and Baton Rouge Crisis Intervention Center to plan and administer Gatekeeper trainings in the coming year. These will focus on school professionals, such as teachers, nurses, coaches, counselors, social workers, and resource officers. The Suicide 101 one-day Gatekeeper training of no less than 50 and no more than 100 school professionals will be conducted in each of the 5 regions of the state. Also 2 two-day Applied Suicide Intervention Skills Training (ASIST) trainings for groups who serve on the regional task force will be conducted. These identified regional leaders will participate in the ASIST training and are required to sign a one-year contract stating that they will serve on the state task force and be responsible for developing activities that are in accordance with the Louisiana Youth Suicide Prevention Plan entitled "LA STAR" Plan to Prevent Youth Suicide.

The Governor's Suicide Prevention Week in September 2005 will include the2ND Louisiana youth walk against suicide, multi-parish planning summits, the Suicide Prevention Day at the Capitol and statewide press release. In conjunction with these activities, the task force is working on 5TH Annual Yellow Ribbon Youth Suicide Prevention Week.

In addition to the trainings, the task force and its member agencies will plan and administer the 1st Multi-Parish Planning Conference in Louisiana. This conference will kick off the Annual Yellow Ribbon Week Activities that are observed in September.

At this Conference, 100 regional leaders, from all nine regions, will be invited, representing various disciplines from within the schools and the community. Invited participants include previously trained Gatekeepers who will be reconvened and updated on the Suicide Prevention Plan, members of the area Crisis Response Team who will serve as the first responders to adolescent suicide attempts and completions and National Speakers who will provide technical assistance. Ultimately, the regional teams will consist of school personnel, mental health workers, police staff, university representative, clergy, youth and survivors.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	88	89	85	85.1	85.2
Annual Indicator	83.3	82.4	84.3	84.4	84.4
Numerator	1137	1243	1099	1162	1162
Denominator	1365	1508	1303	1376	1376
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	84.7	84.8	84.9	85	85.2

Notes - 2002

Data is calendar year.

Notes - 2003

Date is for calendar year.

a. Last Year's Accomplishments

The percentage of Very Low Birth Weight (VLBW) infants born in facilities for high-risk deliveries increased steadily from 80.1% in 1999 to 84.4% in 2003.

Infrastructure Building Services

Maternal and Child Health (MCH), through a partnership with the Louisiana Perinatal Commission, strengthened the concept of evidence-based policy making. In 2003, the Commission drafted revised guidelines for the State Perinatal Plan, which determined neonatal care levels and, in a change from the previous guidelines, determined that there should be a concordance in level between obstetrical and neonatal services, i.e. for a neonatal Level III facility, obstetrical services should be of Level III as well. The revised State Perinatal Plan was presented for public comment. These changes in the perinatal practices throughout the state should help to increase the number of high-risk obstetrical patients that will be referred to and

delivered at higher-level obstetrical facilities

The Louisiana Office of Public Health (OPH) continues, through membership in the Perinatal Commission, to present epidemiological analysis, supporting and providing up-to-date data and information to the Commission. The MCH Program Director and the MCH Maternity Medical Director, as members of the Perinatal Commission, and the MCH Epidemiology group, served as a resource for data and information to the Perinatal Commission regarding VLBW and other relevant MCH issues. This information was used to support the revision of the regionalization of perinatal services.

During 2002-2003, the MCH program initiated the Infant Mortality Reduction Initiative (IMRI), a statewide effort to support regional and local groups, with emphasis in community mobilization. During 2004, the IMRI developed as the core regional MCH group to support policies and advocate for change. During 2004, the regional Feto-Infant Mortality Reviews (FIMR) united into the Louisiana FIMR Network. FIMRs reviewed perinatal deaths statewide and helped determine the most important issues around preventing these deaths in the future. Regions were also involved in the perinatal portion of MCH five-year Needs Assessment and planning process. The Maternity Program and MCH Epidemiology group provided technical assistance.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Study regional distribution of VLBW infants born at all levels in the state, by region & parish.				X
2. Multivariate analysis of risk factors associated with mortality by hospital level and birth weight.				X
3. Analyze survival by weight distribution and hospital level.				X
4. Update MCH Data Book.				X
5. Establish MCH grants for the perinatal mortality reduction initiative.				X
6. Develop regional Feto Infant Mortality Reviews (FIMRs).				X
7. Develop regional MCH Forums.				X
8.				
9.				
10.				

b. Current Activities

Infrastructure Building Services
The MCH program recognizes the need for MCH epidemiologic support and dedicated MCH program development at the regional and local levels. The MCH program expanded the data analysis initiatives through the involvement of the regional epidemiologists in the IMRI and/or the FIMR groups. The lead MCH medical epidemiologist, with the Maternity Medical Director and Maternity Nurse Coordinator, provide coordination and shape to this initiative. While the medical director and the nurse coordinator engage in health promotion and program participation, the MCH epidemiologist acts as the technical advisor and coordinator for the data support to the regional groups.

The core for the success of the initiative continues to be the funding efforts by the MCH program. During this fiscal year, funds were provided to 7 out of the 9 regions. The remaining two groups are being established and are in the final stages of development. The first

Louisiana FIMR Network meeting took place in Lafayette with representation of all regions and FIMR programs. A new Healthy Start grant was awarded in Lafayette and existing Healthy Start grantees were able to renew their grants.

The MCH program is now working to create regional MCH Forums, empowering the regional groups to seek funding and advocate for the MCH agenda. Through continued support from the MCH Epidemiology group, funding from the MCH program, and support by the Maternity Medical Director and Nurse Coordinator, the regional groups will support the revisions of the Perinatal Commission related to the perinatal regionalization. The FIMRs are becoming the regional monitors of this performance measure.

The Perinatal Commission completed the State Perinatal Plan after the public comment period. The plan will undergo final rule publication this year. One of the key changes of the new plan is that facilities must have concordance of levels of maternal and neo-natal care services.

c. Plan for the Coming Year

Objective: Increase to 84.8% the proportion of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

Infrastructure Building Services
The MCH funding for FIMR activities has been implemented throughout the state, with the exception of the New Orleans area and Region 9. These two regions are scheduled to begin FIMRs within the year. OPH will provide support through Technical Assistance and information to ensure success of the program.

The MCH Epidemiology group will continue to provide data to support the MCH regional groups, and to support regional and local applications for other funding sources. The FIMR review teams will provide recommendations to the established Community Action Teams. The Community Action Teams will support measures to increase the VLBW infants being born at facilities with the proper level of care. FIMRs will review cases and continue to support community interventions. The MCH medical epidemiologist will continue to assist these FIMR groups.

Following finalization of the revised Perinatal Plan by the Perinatal Commission, MCH will work with the Commission in monitoring VLBW births delivered at appropriate level facilities The MCH program will contact health providers, stressing participation and compliance with the State Perinatal Plan. MCH will continue to support the changes in hospital licensing and Medicaid reimbursement requirements that will come with the new ruling.

The studies on risk factor analysis for that, and the efforts to monitor the new policies given by the Perinatal Commission, will continue. This effort will provide specific and detailed information on issues that contribute to VLBW births at lower level facilities. Updates to the regional groups will occur and vital statistics analysis will continue to be performed.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance	2000	2001	2002	2003	2004

Data					
Annual Performance Objective	84	85	83.6	83.6	84.5
Annual Indicator	83.3	83.2	83.8	84.1	84.1
Numerator	56295	54037	54204	54305	54305
Denominator	67549	64913	64658	64545	64545
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	85	86	87	88	89

Notes - 2002

Data is calendar year.

Notes - 2003

Data is for calendar year.

a. Last Year's Accomplishments

Early prenatal care has increased from 82.3% in 1998 to 84.1% in 2003. Louisiana has the highest percentage in the West South Central U.S. region and is 25th highest in the nation.

Direct Services
Comprehensive prenatal care services were provided to 4,156 pregnant women through 14,586 visits via the statewide network of parish health units. Nutritionists provided assessment and counseling to 8,978 pregnant women. Over 14,410 pregnancy tests were performed. WIC benefits and health education were provided to 39,915 women through the parish health units. In medically underserved areas, contractors provided prenatal services to 803 low income women, with approximately 6,608 visits.

Enabling Services
The Nurse Family Partnership (NFP) provided home visits and case management to 1,242 first-time Moms for a total of 14,879 visits. Home visits are provided during pregnancy and continue until the child's second birthday. New Orleans Healthy Start initiated case management services, to additional sites and populations, serving 240 women.

The Teen Advocacy Program in Baton Rouge served 153 pregnant or parenting teens and provided 51 presentations to 1204 adolescents on health-related topics. MCH funded an outreach/case management program in the Northeast Healthy Start area that provided services to 119 pregnant women. MCH provided funding to Family Road of Greater Baton Rouge (a Healthy Start site), which provided prenatal services to 326 clients, 1,067 home visitations, 405 referrals to community agencies, 52 childcare assistance referrals and 7,022 family support referrals. The Louisiana Risk Assessment (LRA) tool, a self-report screening tool to identify women at risk for psychosocial problems, was successfully piloted in 6 parish health units.

Population-Based Services
The Partners for Healthy Babies social marketing campaign continued to focus on proper weight gain during in pregnancy, oral health and other low birth weight risk factors The Helpline received 4092 calls in FY 2004. A new website for target population and providers was launched in January 2004. In CY 2004, the website had 4,216 sessions, 19,881 page views

and 163,614 hits.

Infrastructure Building Services
In 2004, site evaluations were completed in all regions participating in prenatal services. All sites were found to provide adequate services; problematic issues were addressed through follow-up. A patient feedback survey was conducted in Region 8 that encompassed Family Planning, Maternity and Child Health Services. Comments made included "courteous staff" and "some working moms could use after hours clinics." Comments are being addressed by the regional administration. Parishes in the lowest quartile for late entry and inadequate prenatal care were identified. This information was provided to regional Infant Mortality Reduction Initiative coordinators and utilized in regional needs assessment and strategic planning.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provision of prenatal services via network of parish health units and contract agencies.	X			
2. Provide targeted case management programs, such as Nurse Family Partnership.		X		
3. Link women to prenatal care via the Partners for Healthy Babies social marketing project Helpline.			X	
4. Collect and analyze PRAMS data to provide program direction.				X
5. Provide Quality Assurance and program monitoring of all MCH funded prenatal services.				X
6. Develop Regional Infant Mortality Reduction infrastructure, at each regional level, using Coordinators.				X
7.				
8.				
9.				
10.				

b. Current Activities

Direct and Enabling Services
The NFP program provides case management and home visiting in all 9 regions (28 parishes) to first-time pregnant women who qualify for Medicaid. From October 2004 through March 2005, 1156 clients were seen with 8733 visits. Prenatal clinics, outreach and case management services in Shreveport are ongoing. Case management and outreach continue at the Baton Rouge Family Road site. New Orleans Healthy Start extension program provided case management to 245 women and clinical mental health treatment to 83 women, through May 2005. MCH also supports prenatal clinics in Region 1, including Orleans and Jefferson parishes. The LRA was implemented in 6 regions. Nurse and social work staff were trained on usage and implementation of the tool.

Population-Based Services
The PHB continues to employ a mix of communication strategies including multi-media advertising, (TV/Radio/Outdoor) educational materials (brochures, fliers, posters, newsletters) and group communication (speeches, health fairs, promotions). A contract has been developed for a new helpline provider and will be an improved, one-stop-referral for women's reproductive needs. The comprehensive PHB website is being evaluated, updated, and maintained. A

benchmark evaluative statewide survey is being conducted to assess campaign impact and help with future direction.

Infrastructure Building Services
Quality assurance is conducted for each prenatal care site funded by the MCH Block Grant. The state maternity nursing consultants assure that training and quality improvement are conducted.

The Maternity Program Medical Director, the MCH Epidemiologist-CDC assignee, and the Nurse Consultant coordinate the statewide Infant Mortality Reduction Initiative (IMRI) to link state agencies, public and private providers to address and improve birth outcomes. The Fetal and Infant Mortality Reduction (FIMR) process is active in 7 of the 9 regions, with the other two regions beginning in July 2005. The Medical Director and Nurse Coordinator performed "MCH detailing" visits to private providers and birthing hospitals.

Parishes in the lowest quartile for late entry and inadequate prenatal care are being targeted and, working through regional IMRI and public health, public and private providers will be invited to a local meeting to review the data and formulate a strategy to improve. With Partners for Healthy Babies assistance, a local media effort will ensue. The targeted campaign will continue for 3 years, with monitoring for improvement.

The Partners for Healthy Babies project works in coordination with the LaMOMS program, to assist in publicizing their program at outreach events. The LaMOMS program enrolled close to 5400 women in 2004 in the new expansion eligibility category, women who would not have qualified for Medicaid coverage prior to expansion to 200% of the federal poverty level.

c. Plan for the Coming Year

Objective: Increase the proportion of infants born to pregnant women receiving prenatal care beginning in the first trimester to 86%.

Direct Services
Parishes in the lowest quartile for first trimester entry into prenatal care will be targeted for the development of additional prenatal initiatives

Enabling Services
From October of 2005 through September 2006, the LRA will provide screening for high risk for poor developmental/social-emotional outcomes for at least half of the infants seen for WIC certification statewide, and referral to local substance abuse, domestic violence, and mental health services, including the Best Start and Nurse Family Partnership programs, throughout the state. New Orleans Healthy Start extension program will provide case management services to 300 women and clinical services to 80 women.

Population-Based Services
Partners for Healthy Babies will continue to work in conjunction with the state maternity medical director to reach out to high-risk areas of the state, including the private provider community and conduct extensive media messaging, public relations, and other activities in these areas. Continued coordination is planned with the LaMOMS program to provide outreach to, and recruitment of pregnant women. Plans to expand and restructure the Helpline services as well as the website are also underway.

Infrastructure Building Services

The Louisiana Fetal and Infant Mortality Reduction Initiative (FIMR) is being expanded to create Regional Forums that will serve as umbrella organizations within the community for

MCH issues. Regional FIMRs are expanding focus on diversity and cultural competence in strategic planning for the Community Action Teams. The Maternity Medical Director and Nurse Consultant are expanding the statewide direct detailing visits to providers and hospitals of high-risk obstetrical populations. Collaboration with Medicaid will focus on transportation issues and information on "Friends and Family" transportation program. Native American tribal groups will be evaluated and targeted for expansion of prenatal services.

Continued collaboration with Partners for Healthy Babies will be developed targeting both patients and providers on the need for early entry into care. New parishes with poor performance on early and adequate prenatal care will be identified, and given targeted technical assistance.

MCH will continue to monitor quality assurance systems at all levels and Continuous Quality Improvement Programs will be initiated for contract sites and regional FIMRs. Newly available 2003 PRAMS data is being analyzed and the final report will be widely distributed to stakeholders and made available through the Internet.

D. STATE PERFORMANCE MEASURES

State Performance Measure 1: *Percent of all children and adolescents enrolled in public schools in Louisiana that have access to school-based health center services.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	6.5	6.1	7.1	6.9	6.9
Annual Indicator	5.2	6.1	6.9	6.9	7.0
Numerator	39329	45203	50334	48494	49464
Denominator	756579	741553	730252	706119	704129
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	6.9	7.1	7.3	7.5	7.7

Notes - 2002

The objective for 2003 remains at 6.9 because no funding has been provided for expansion.

a. Last Year's Accomplishments

The number of students with access to a school-based health center (SBHC) is 7.0% of the approximate 704,129 students enrolled in public schools. There were 53 state-funded, 1 federally funded, and 1 foundation-funded SBHCs. The Adolescent School Health Initiative (ASHI) did reach its goal of 6.9% of students enrolled.

Direct Services

The State Legislature appropriated an additional $264,800 to expand services at existing SBHCs for 2003-04. No new state funded SBHC opened but Rapides Foundation funded one in Natchitoches Parish. The SBHCs provide comprehensive primary and preventive physical and mental health services. The number of SBHCs participating in laboratory testing for STDs and cervical cancer screening increased to 19. SBHCs continue to screen high-risk students for type 2 diabetes. Of 1,130 screens performed, 9 (0.8%) of tests were positive. All children with positive tests were referred for further evaluation and management.

Infrastructure Building Services
CommunityCARE, Louisiana's Medicaid managed care program, is now in all parishes as of December 2003. It is based on primary care case management, linking Medicaid recipients with a primary care physician, Rural Health Center (RHC) or Federally Qualified Health Center (FQHC). ASHI was successful in obtaining an exemption for SBHCs from CommunityCARE's primary care physician prior authorization requirement. SBHC Medicaid revenues would have been negatively impacted without this exemption. Now SBHCs will be able to continue to bill Medicaid, as they have in the past, for services provided to recipients 10 years and older. The process of enrolling SBHCs as an "SBHC Medicaid Provider" type began.

Nine SBHC sponsors underwent a rigorous on-site Continuous Quality Improvement (CQI) review. A new outcome-based CQI tool was piloted at two sites. ASHI continued its Best Practices Initiative, coordinating educational workshops for SBHC staff based on clinical guidelines set by national experts. In 2003-04, the focus was obesity management. Teams of professionals from 6 SBHCs began implementing a pediatric weight management program developed by experts from Louisiana State University Health Sciences Center. ASHI coordinated an initial training on this researched program in November of 2003 and a follow-up videoconference in April 2004.

Nearly all of the 55 SBHCs are LaCHIP/Medicaid application centers. Through LaCHIP outreach efforts, SBHC staff decreased the percentage of uninsured students enrolled in SBHCs from 18% to 13%. Documentation of up-to-date immunization determined by random chart audits increased from 59% to 83% by the end of the school year.

ASHI continues to work with the Department of Education (DOE) and other agencies and groups to promote coordinated school health. In February 2004, ASHI participated in an Abstinence Summit sponsored by DOE.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. SBHCs provide comprehensive preventive and primary physical and mental health services.	X	X		
2. Set policies and standards for SBHC operation.				X
3. Provide technical assistance, monitoring, continuous quality improvement in SBHCs.	X			X
4. Work to raise level of funding to support SBHC operation.				X
5. Publish Louisiana School-Based Health Centers Annual Services Report.				X
6. Collaborate with various entities to promote coordinated school health model.				X
7. Provide resources to policy makers, educators, service providers, etc.				

on school health issues.				X
8. Generate statistical reports on service delivery in Louisiana SBHCs.				X
9.				
10.				

b. Current Activities

Direct Services
The ASHI Program continues to fund, provide technical assistance, and monitor the state-funded SBHCs. No new funds were allocated for SBHCs in 2004-05. Lawless High School's SBHC did reopen in 2004-05 after closing in 2002-03. There are now 54 OPH funded SBHCs, 1 federally funded SBHC, and 1 Rapides Foundation funded SBHC serving 89 schools. SBHCs continue to screen students at risk for Type 2 diabetes. MCH funding for on-site provision of STD screening, diagnosis and treatment, as well as cervical cancer screening at the SBHCs continues to expand with 21 SBHCs now participating.

Teams of professionals from two SBHCs continue to implement the Committed to Kids in SBHCs obesity management program. Forty weeks of data at these two sites demonstrated that 50% of participating students decreased or maintained their body mass index (BMI) compared to baseline.

Infrastructure Building Services
The process of enrolling centers as a "SBHC Medicaid Provider" type was completed and SBHCs are now successfully billing Medicaid. Discussions are ongoing with Medicaid regarding (1) the possibility of allowing SBHCs to bill for services provided by licensed mental health professionals and (2) SBHCs becoming CommunityCARE providers.

In collaboration with the Louisiana Primary Care Association and the Bureau of Primary Care and Rural Health, ASHI has developed a pamphlet describing funding sources for SBHCs in Louisiana. In addition, the two agencies have linked websites.

Seven SBHCs will undergo an on-site CQI review in 2004-2005. ASHI has developed a new CQI tool and has begun using it for site visits. The new tool assesses the quality of clinical services and data management through core sentinel conditions and consists primarily of patient chart audits and data management assessment.

ASHI continues to collaborate with DOE, community-based organizations, and the Medicaid Program to develop strategies to increase school-based LaCHIP outreach. ASHI also helped organize and participate in an abstinence summit sponsored by the Louisiana Department of Education in February 2005.

c. Plan for the Coming Year

Objective: Maintain the percent of all children and adolescents enrolled in public schools in Louisiana that have access to school-based health centers at 7.1%.

Although access to health care was found to be a top need of Louisiana adolescents, it is not anticipated that additional funding to plan and subsequently operate additional SBHCs will be allocated during the 2005 Louisiana Legislative Session. This is because of the state and agency budget crisis. The agency required that, MCH Block Grant dollars for SBHCs be cut by $200,000 in 2005-06. Consequently SBHC contracts for 2005-06 have been cut and no new state-funded SBHCs will open in 2005-2006.

Direct Services
The ASHI Program will continue to fund, provide technical assistance, and monitor the state-

funded SBHCs. Current services provided will continue to be available to students served by SBHCs. The STD screening program will continue to be expanded.

Infrastructure Building Services
The MCH Needs Assessment process found mental health, substance abuse, and access to health care to be the top three priority needs of adolescents. In response to these needs, OPH-ASHI will continue to work with Medicaid and the Offices of Mental Health and Addictive Disorders to develop strategies to expand school-based mental health and substance abuse services. ASHI will also continue to work with Medicaid to improve SBHC Medicaid reimbursement.

ASHI will continue to use the new outcome based CQI tool on SBHC site visits. ASHI will analysis evaluation data from sites participating in the Committed to Kids in SBHCs Program. ASHI will continue to collaborate with DOE and other agencies to promote and support coordinated school health programming.

State Performance Measure 2: *Percent of women in need of family planning services who have received such services.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	22.0	22.0	23.0	23	23.5
Annual Indicator	20.0	21.7	22.7	23.8	25.4
Numerator	62798	68054	71429	74885	77228
Denominator	314000	314000	314000	314000	304270
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	24	24.5	25	25.5	26

Notes - 2002
Data is calendar year.

The denominator is from the Guttmacher Institute's 1995 estimate of women in need of publicly funded family planning services by state, and remains constant until the Institute updates the estimates.

Notes - 2003
Data is for calendar year.

Notes - 2004
Data is for calendar year.

a. Last Year's Accomplishments

In 2004, 77,288 clients received comprehensive reproductive health care services through the Family Planning Program (FPP). This figure represents 25.4% of the estimated 304,270 women in need of publicly funded family planning services in Louisiana. In the year of 2003, the total number of clients receiving such services was 74,885. An estimated eighty percent of these women were at 100% of the federal poverty level or below. Unplanned pregnancies are associated with higher rates of health problems for mother and baby

Direct Services
The Office of Public Health (OPH) Family Planning Program receives supplemental funding from Title V and provides comprehensive medical, educational, nutritional, psychosocial, and reproductive health care services to women and men. Currently the Family Planning Program provides services in 69 state-administered facilities and 24 contract sites. Eleven of these sites provide services after 4:30pm on weekdays and/or on Saturday mornings. In 2004, the FPP was able to use Title X expansion funding to enhance staffing patterns in underserved areas of the state. Three advance practice nurses have been maintained in two regions with "high" or "very high" health professional shortages.

Population-Based Services

In 2004, approximately 45,000 brochures were distributed by the Forms Management Warehouse to our service sites. Adolescent Health Initiative Program provided outreach and education services to 15,670 people through outreach and education activities. In 2004, a variety of regional and statewide trainings were conducted for the providers. Contractors are invited and encouraged to participate in all training activities.

Infrastructure Building Services
Ongoing training in new contraceptive methods, supportive services, and client-centered care assured the quality of care provided in all parts of the state. Trainings were conducted on both regional and statewide levels and took advantage of opportunities to reach a large audience representing the range of health care providers.

Monitoring of most contract sites occurs at the regional level. Regional Medical Directors and other staff have been provided with the Clinical Contracts Monitoring Manual as well as additional training on conducting monitoring site visits. With turnover of contract sites, monitoring efforts take on added importance to ensure quality of services as well as to identify issues that need immediate remediation and to promote the longevity of the contract site. To this end, each region submitted a schedule for contract monitoring site visits for the coming year. Based on this information, a master calendar has been created to facilitate follow-up from the central office.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provision of family planning services throughout the state in over 70 sites.	X	X		
2. Improving efficiency and quality of care in state-run and contract service sites.				X
3. Provision of community outreach and education to women in need of family planning services.		X		
4. Training of family planning service providers on topics that enhance				

family planning services.			X	X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Direct Services
The Family Planning Program continues to provide comprehensive reproductive health care services to men and women. Because of budgetary constraints, the FPP had to terminate contracts with 19 providers in March 2005. This change in the provision of direct services will affect the access to reproductive health services. The FPP central office is paying close attention to this matter is exploring ways to overcome the deficit.

Population-Based Services
The Family Planning Program provides outreach to young men and women in the New Orleans and Baton Rouge areas through contracts with local community based organizations. A team of workers provides one-on-one and group reproductive health information to women and men in target areas of each city that includes referrals to Family Planning Program clinic sites. In the New Orleans area, young men and women under the age of 24 are the focus of the intervention. In Baton Rouge, commercial sex workers in 3 zip code areas receive the outreach education.

Infrastructure Building Services
The Family Planning Program's Training Manager coordinated 28 training events from October 2004 to the present. Altogether, 1695 health professionals have been trained.

Monitoring of individual clinic sites, which occurs on a regional level, identifies areas that need remediation and improvement and the central office serves as a repository for all site visit reports. In this way, regional or statewide trends in service delivery can be assessed. It is the responsibility of FPP central office staff to ensure that all administrative and medical protocols are current and appropriate, and that all clinic sites have the resources to follow them. Both an annual, comprehensive review of the program manuals and an ongoing review of developments in reproductive health will ensure that clinics are able to offer high quality services.

c. Plan for the Coming Year

Objective: Maintain the capacity to serve the targeted Annual Performance Objective for the year 2006 of the 24.5% of the proportion of women in need of publicly funded family planning services.

Direct Services
To maintain and improve the FPP's ability to serve the women in need of family planning services, the FPP plans to retain all the state-run and the remaining contract service sites. The FPP central office will explore measures to improve efficiency of existing clinics and improve the quality of services provided at the service sites.

Enabling Services
Through targeted outreach and education activities of the FPP Health Education and Outreach Coordinator and field and contract staff, the program will attempt to increase utilization of

services by the women most in need. Specific activities focused on incarcerated women and commercial sex workers will include individual and small group reproductive health education, counseling and referral to services.

Infrastructure Building Services
The FPP relies on quality data for federal reporting requirements as well as for program evaluation. In light of new agency-wide systems already installed for data collection, procedures for data verification on several levels are being developed to ensure completeness and accuracy of data at its source. Quality assessments will also be conducted to test these procedures.

The FPP plans to continue training activities on topics like emerging contraceptive technology, client-centered care, and clinic efficiency. These training activities will improve the quality of care while also increasing the program's capacity to provide services. Training activities are based on the findings of the annual statewide training needs assessment, as conducted by the FPP's Training Manager.

State Performance Measure 3: *Rate of children (per 1,000) under 18 who have been abused or neglected.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective	10.0	9.9	8.3	8.2	7.7
Annual Indicator	8.3	8.4	8.3	8.8	7.8
Numerator	10139	10270	10081	10744	9564
Denominator	1220031	1220031	1220031	1224027	1224027
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	7.6	7.5	7.4	7.3	7.2

Notes - 2002
Data is calendar year.

FY 2001 and 2002 denominators report 2000 population estimates from the US Census Bureau.

FY 2002 data is from the Office of Community Services. Measures reported prior to 2001 reported validated allegations of child abuse and neglect (duplicated counts), rather than the number of unduplicated victims. In FY 2001, unduplicated victims were reported. Data has been adjusted back to 1998 to consistently report unduplicated victims.

Notes - 2003

2003 Denominator is from factfinder.census.gov, "DP-1: Profile of General Demographic Characteristics: 2000," for ages 0-19.

a. Last Year's Accomplishments

There were 13,241 validated allegations of abuse and neglect in children under age 18 in Louisiana for FY 2004. This represents an unduplicated count of 9,564 victims, slightly lower than the unduplicated count of 10,744 victims in FY 2003.

Direct Services

MCH clinics use a Child Health Record for children ages 0 to 6 that includes a psychosocial assessment of infants and children by parish health unit (PHU) nurses. Parish health unit staff provides parent education, counseling, and educational materials for families. MCH has a joint agreement with the Office of Community Services (OCS) to utilize local public health nurses to assist child protection workers in the investigation of families suspected of child abuse and neglect. During FY 2004, 68 children were assessed by public health nurses, assisting with the OCS investigation. Healthy Beginnings, an infant mental health program, received 81 new referrals for preventive intervention mental health services to infants and young children ages 0-5 and their families.

MCH contracted with Children's Bureau of New Orleans to provide clinical grief/trauma assessments, home and school based family and group therapy and crisis intervention services. In 2004, Children's Bureau provided services to 120 children and 167 adults.

Enabling Services

Louisiana's Healthy Families program served over 340 low-income families. Louisiana began to retool the psychosocial services provided to pregnant women and their infants. The new program will focus on abuse and neglect by screening for risk, providing better access to basic services, and strengthening the parent-infant relationship

The Nurse-Family Partnership (NFP) program added three new teams this fiscal year for a total of 10 teams in 19 parishes. Between October 2003 and September 2004, 1,242 families, including 837 babies, were served by this program. Clinical trials and longitudinal studies have shown that this prevention model significantly reduces verified reports of child abuse and neglect.

Population-Based Services

During this period, the Prevent Child Abuse Louisiana helpline number was changed to 1-800-CHILDREN, and between October 2003 and September 2004, 1194 calls were placed to the parenting helpline.

Thirty-five public health nurses and social workers, as well as social workers and case managers from the Office of Mental Health's Early Childhood Supports and Services (ECSS) received training in infant mental health (IMH). This 30-hour curriculum provides information and skills regarding early social-emotional development and parenting to improve identification of risk factors for child abuse and neglect.

The Child Death Review Panel (CDRP) facilitated 10 local panels across the state to review unexpected infant deaths and make recommendations for prevention of further deaths.

Dental professionals from the Oral Health Program (OHP) reported six abuse and/or neglect cases in FY 2004; four were invalid, one was opened in error, and one was validated.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Child Health Record psychosocial assessment for children 0-6 in health units.	X			
2. Home visitation services for low-income families.		X		
3. Infant mental health services to low-income families through Healthy Beginnings program.		X		
4. Statewide infant mental health training to public health nurses.				X
5. Outreach and public education through Prevent Child Abuse Louisiana's media campaign and speakers' bureau.			X	
6. Collection, analysis, and assessment of unexpected child deaths by the Child Death Review Panel.				X
7. Prevent Child Abuse and Neglect through Dental Awareness (PANDA) training of dental professionals.				X
8. Public education through new parent's newsletter, Happy and Healthy Kids.			X	
9. Targeted psycho-educational services for at-risk mothers.		X		
10.				

b. Current Activities

Direct Services
Healthy Beginnings served more than 28 new families from October 2004 through March 2005. As of April 2005, Healthy Beginnings was incorporated into the Office of Mental Health's ECSS program, which is expanding into Orleans Parish. ECSS provides comprehensive social and mental health services to young children 0-6 years of age and their families. ECSS is supported by TANF and state general funds.

Enabling Services
The 4 MCH-funded home visiting programs that follow the Healthy Families America (HFA) model to prevent child abuse and neglect were transitioned into PHU-based prevention/intervention infant mental health programs, entitled Best Start. Program design, development, and staffing for Best Start, which uses professional therapists, occurred, with the program officially beginning in March 2005. Five sites, offering intervention groups, and individual mental health therapy with a mental health clinician and nurse, are operating in 4 parishes and Alexandria.

The Nurse Family Partnership (NFP) added two partial teams, and provided services in 27 of the 64 parishes of the state. Between October 2004 and March 2005, 1156 families were served, including 798 infants. Since the inception of the NFP program in 1999 through March 2005, the NFP completed 57,686 visits, reaching 5,001 families, including 2,179 babies. There is only one instance of known physical abuse, and a total of 18 instances of known validated neglect, a rate of approximately 8.5 instances of validated abuse/1000, compared to 11/1000 estimated from the Office of Child Protection figures. A recent randomized-controlled study on NFP in one region of the state found that the majority of Emergency Room (ER) visits by NFP clients during the first year of life were due to illness versus injury (94% vs. 6%), with no ER visits reported for ingestions, suggesting that NFP recipients experience few significant injuries, likely reflecting safer home environments and better supervision by their caregivers.

Population-Based Services

The PCAL Parenting Helpline received 711 calls between October 2004 and April 2005; if calls continue at this rate, it will represent a 17% increase in the use of the service over the previous year.

Infrastructure Building Services
Over 33 public health nurses and social workers, and case managers from ECSS, received the 30-hour Infant Mental Health training. Several OPH staff were on the planning committee for Prevent Child Abuse Louisiana's "Kids Are Worth It!" Conference held in March 2005. In addition, OPH provided Nursing CE credit for the conference. It was attended by 351 professionals.

The Oral Health Program conducted a 3-hour continuing education program for the LSUHSC School of Dentistry dental faculty on recognizing signs of abuse and neglect and the reporting requirements in October 2004.

The Child Death Review Panel facilitated 11 local panels across the state to review unexpected infant deaths and make recommendations for prevention.

c. Plan for the Coming Year

Objective: To reduce the rate of children (per 1,000) under 18 who have been abused or neglected to 7.5.

Direct Services and Enabling Services
MCH has re-allocated funding for the HFA home visitation program to Best Start, to provide screening, case management, psycho-educational support, limited individual counseling, and referral services in the current HFA communities. Training and supervision for the staff in these programs is being provided and program monitoring to assure program quality. The Program is expected to reach 260-300 families.

The NFP Program now exists in all 9 regions of the state, including 27 of the 64 parishes. The program does not plan to add additional parishes in the coming year, pending budget constraints. At present, 7 of the 9 regions have Medicaid funding, and administrative approvals for Medicaid funding for the remaining two regions is planned.

MCH will continue to provide clinical grief/trauma services to children and families in Orleans and Jefferson Parish, through a contract with Children's Bureau.

Population-Based Services
MCH will begin distribution of the new parenting newsletter series, Happy and Healthy Kids, to all new parents. This newsletter focuses on psychosocial development and positive parenting. Twenty-eight issues have been designed to cover the prenatal period through 5 years of age. We expect that 65,000 Louisiana families will receive the newsletter in the first year. Issues will be distributed through our public health units, birthing hospitals throughout the state, and with the Vital Records complimentary birth certificate.

Infrastructure Building Services
Infant Mental Health trainings will continue to be offered throughout the state. OPH and OMH will develop a Memorandum of Understanding to ensure sustainability of infant mental health consultation services for the NFP program.

CDRP's plans for next year include: 1) continue to develop local panels; 2) develop an initial contact investigative report form for first responders to utilize in unexpected deaths of children under age 15; 3) conduct an assessment on the reporting of deaths to the panel in a timely manner; and 4) initiate prevention programs on statewide and local levels.

The SIDS Program continues to provide reimbursement for autopsies and death scene investigations for unexpected infant deaths. Autopsy and death scene investigations are necessary to rule out another cause of death such as suffocation, poisoning, or child abuse and thereby support the diagnosis of SIDS as the cause of death. A training of Coroner's Offices and Death Scene Investigators is planned for the next year to improve death scene investigations for the determination of Sudden Infant Death Syndrome. The Oral Health Program will continue to monitor the number of abuse and neglect cases reported by dental professionals. This information will be reported in the Louisiana Dental Association Journal and the Louisiana Dental Hygienist Association Newsletter.

State Performance Measure 4: *Percent of CSHS patients with case management (follow-up visits) from a nurse, social worker, or nutritionist.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	20.0	40	45	52	55
Annual Indicator	37.6	40.0	48.0	53.2	51.5
Numerator	6906	7983	2776	3041	2760
Denominator	18368	19957	5781	5711	5363
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	57	60	65	67	69

Notes - 2002

FY 1998 through 2001 data was an estimate based on percentage of visits, rather than patients. FY 2002 data is a more accurate measure based on an unduplicated count of patients who received follow-up.

Notes - 2003

The 2003 indicator is based on the State estimates from SLAITS.

a. Last Year's Accomplishments

During fiscal year 2003, 53% of Children's Special Health Services (CSHS) patients had received follow-up services. During fiscal year 2004, approximately 51% of CSHS patients received follow-up services from a nurse, social worker, or nutritionist. This decline may be due to a change in the data collecting system and training staff on how to use the new system. The annual performance objective was 55%.

Direct Services
In each of the nine regions in the state, CSHS staff provided follow-up care to patients to implement plans of care, facilitate linkages to needed services, in addition to any other care coordination needs identified by families. During follow-up, CSHS nurses, social workers, and nutritionists tried to ensure that families understood what had been communicated to them during clinic visits and were in agreement with the plan of care. In addition, CSHS Central Office staff designed a Transition Program for those patients and families who will be exiting the CSHS program and entering adult services. The program was piloted during this past year beginning with those patients who were 14 years old at the time of their clinic visit. Staff was trained on this new policy at a meeting in New Orleans in September 2004 and other locations throughout the state.

Enabling Services
CSHS staff provided follow-up services to families either by self-referral, physician-referral, or through their own efforts. They continued to form relationships with families to build trust and confidence. Staff worked with all families attending CSHS clinics to ensure that each child was linked to a primary care physician. Staff also worked with families to assure that all Community Care referrals were in order and that families understood the process for obtaining referrals.

Population Services
CSHS has been participating in the Medical Home Learning Collaborative by funding several Care Coordinators in physician practices in the community. These coordinators have linked families with needed community resources, provided health education to families, coordinated services, and provided follow-up and monitoring of the child's medical management plan. Training and ongoing technical assistance was provided to these Care Coordinators by the CSHS Transition Coordinator.

Infrastructure Building Services
CSHS continued working on the Medical Home Learning Collaborative. This grant has provided training and support to OPH staff and to pediatric providers in the community to set up Medical Home models. In addition, contracts were initiated with three pediatric practices to hire Care Coordinators to provide enhanced care coordination services for children with special health care needs within these practices. The goal of this initiative is to increase follow-up for children identified with special health care needs.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Execute Long Range Plan Needs Assessment to evaluate capacity to provide case management services for CSHCN.				X
2. Provide case management services for children attending CSHS clinics.		X		
3. Provide assessment and linkage to needed services for CSHCN.		X		
4. Collaborate with primary care practices to improve case management for CSHCN.		X		
5. Provide transition services for adolescents aged 14 & 15.	X			
6. Facilitate system of follow-up through Medical Home practices.				X
7. Establish enhanced Care Coordination activities.				X
8.				

9.				
10.				

b. Current Activities

Direct Services
Clinic staff in each region continue to provide follow up care to families served by CSHS to implement plans of care, provide linkages to needed resources, and assist with care coordination. Follow-up also includes assisting the patients and their families during clinic to ensure that they understand and are in agreement with the plan of care. Staff also provides assistance by ensuring that families are equipped with everything that is needed for any prescriptions, durable medical equipment, or upcoming procedures. Staff is also in the process of adding 15-year-old patients to those being assessed for transition services.

Population Based Services
CSHS staff continues to provide follow-up care to patients and families seen in CSHS clinics. They continue to work with existing patients and to form relationships with new patients. They work diligently to ensure that care is provided in a compassionate, coordinated, culturally sensitive manner. Input from the rest of the team, which includes Parent Liaisons, helps assure cultural sensitivity and the ability to comprehensively address all barriers to care.

Enabling Services
CSHS continues to partner with three pediatric practices in the Medical Home project. A Care Coordinator was added to a third pediatric practice in late 2004. These Care Coordinators link families to community resources and provide teaching in order to give families a better understanding of their child's medical issues. They also provide follow-up care and assist with medical management of children identified with special health care needs.

Infrastructure Building
In October 2004, CSHS held a conference for all staff and partners to reveal the results of the Long Range Plan Needs Assessment. CSHS Central Office staff will now begin the task of studying the results in an effort to make decisions concerning the future of service delivery to CSHS patients.

c. Plan for the Coming Year

Direct Services
CSHS staff will continue to provide follow-up services to patients in clinics. Staff will continue to assist in the implementation of the plan of care, provide linkages with resources, and assist in care coordination activities. Staff will also work to ensure that families of children in CSHS clinics understand and are in agreement with the plan of care. As the CSHS program implements its Long Range Plan, care coordination activities will be increased and direct clinic services decreased. This performance indicator will also address the new state priority need "Promote comprehensive systems of care and seamless transition to adult services for the Children with Special Health Care Needs population by providing care coordination."

Enabling Services
CSHS staff will continue to assist with the Medical Home project by providing technical assistance and training when needed, as a means to enhance care coordination services in the private medical sector. State Social Work Consultant will continue to provide assistance to CSHS staff and to provide training on social work issues. In addition brochures and other information will be made available to patients who are preparing to transition from CSHS to adult services.

Population Based Services
Staff will continue to work with the Medical Home project, and will continue working to improve

and expand the Transition Program for those patients moving from CSHS into adult care. Staff will also continue to work with families to ensure that all patients have a Medical Home and the families know the procedures for acquiring Community Care referrals.

Infrastructure Building Services
Based on the results of the Long Range Plan Needs Assessment, CSHS Central Office Staff will continue to develop a plan for the future of service delivery for CSHS patients. Staff will also build partnerships within their respective communities with providers and other agencies that serve young adults in an effort to facilitate the transition process for patients and their families. CSHS will also implement an enhanced care coordination model and will provide training to field staff in the near future.

State Performance Measure 5: *Percent of children (2 - 5 years old) on WIC greater than or equal to the 95th percentile for BMI-for-age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	8.3	9.0	9.0	13.4	13.3
Annual Indicator	11.2	12.1	13.5	13.3	14.0
Numerator	3334	4776	5774	5847	6903
Denominator	29762	39468	42767	44036	49302
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	13.2	13.1	13	12.9	12.9

Notes - 2002
The data reported for 2002 is based on Body Mass Index (BMI) greater than or equal to 95% for children aged 2-5 years. This is different from the measure used previously based on greater than or equal to 95% weight for height for children aged 0-5 years. This change was made due to the implementation of the new CDC growth charts which utilize BMI of children over 2 years of age. BMI over the 95th percentile is more predictive of overweight at older ages.

Data has been updated from 1998-present.

a. Last Year's Accomplishments

The Louisiana National Pediatric Nutrition Surveillance System (PedNSS) indicates an upward trend in overweight children. In Louisiana, over the last decade (1993 -- 2003), the percent of overweight children in the WIC Program ages = 2 to <5 years increased from 9.3% to 13.3% compared to national increase from 10.7% to 14.7%. Louisiana has 14.0% of children (ages 2-

5) on WIC greater than or equal to the 95th percentile for BMI-for-age in 2004 as compared to the national percent of 14.7% in 2003.

Direct Services
In the Office of Public Health (OPH), nutritionists, nurses, health educators and nutrition educators provide counseling and education sessions to families statewide on healthy eating and physical activity. During this period 29,943 families with children were provided counseling sessions. Referrals are made to WIC Services for specialized nutrition counseling.

Enabling Services
The Office of Public Health utilizes the revised BMI-for-age growth charts for children. These provide at-risk children the opportunity for early identification and preventive interventions.

A positive feeding relationship is essential for a child's proper nutrition and growth. To promote a healthy feeding relationship, three brochures entitled "Mealtime Magic" were developed for stage-related feeding. A poster was also developed to accompany the Mealtime Magic brochures. To ensure quality health education while utilizing the Mealtime Magic brochures we developed a self-instructional manual and a facilitative nutrition session. All components were presented and discussed at the statewide Nutrition Education Conference in July 2004 to approximately 200 nutritionists, nurses and nutrition educators who work in the Public Health Units throughout the state. Training on the prevention of childhood obesity was also presented.

Office of Public Health professionals and educators continue to incorporate childhood obesity education into nutrition education statewide by utilizing the two patient education cards that were developed by MCH/WIC programs on childhood obesity and the series of three brochures, "Play With Me!"

Population-Based Services
MCH actively participated in the Lighten Up Louisiana campaign. This statewide campaign was a four-month competition, August to December 2004 that encouraged Louisianans to develop healthy activity and eating habits.

Infrastructure Building Services
MCH actively participates in the Louisiana Council on Obesity Prevention and Management, a council mandated by state legislation, composed of both public and private experts on the obesity issue. The council was instrumental in passing legislation that requires 30 minutes of physical activity in public schools grades k-5 each day.

MCH actively participates in the Body Wise Program, which provides classroom education session on healthy eating habits at the Lusher Middle School in New Orleans. A presentation was also made at the school during a "Day of Health" in April 2004.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Counseling and education sessions to families on healthy eating and physical activity.		X		
2. Referrals to WIC Services for specialized one-on-one nutrition counseling.		X		
3. Implementation of the revised BMI-for-age growth charts for children by clinics and health units.	X			

4. Development of educational materials on healthy weight & physical activity for infants and children.				X
5. Training of health providers to enhance their abilities to promote healthy lifestyles with patients.				X
6. Participation in the Louisiana Obesity Council.				X
7. Implementation of guidelines for health professionals on healthy weight and physical activities.		X		
8. Participate in the Body Wise Program which provides classroom education session on healthy eating habits and a one-day health promotion day.				X
9. Work with the Family Planning Program and the Title X's Region 6 regional office on a project to address obesity in family planning clinics.		X		
10.				

b. Current Activities

Direct Services
Counseling and education sessions as well as referrals to WIC continue to be provided as previously described.

Enabling Services
MCH actively participates in the Southwest Regional USDA committee to address childhood obesity. The committee has developed training modules for health professionals and tabletop message modules for patient education. Distribution and training of the two modules will be implemented throughout the state in early fall.

To promote healthy eating habits and physical activity within the family to support children's healthy weight management and growth, MCH is working with the Family Planning Program and the Title X's Region 6 regional office on a project to address obesity in family planning clinics.

Infrastructure Building Services:
The 5-a-Day program is promoted through health fairs throughout the state. MCH continues to actively participate in the Louisiana Council on Obesity Prevention and Management.

c. Plan for the Coming Year

Objective: Reduce the percent of children (2-5 years old) on WIC greater than or equal to the 95th percentile for BMI-for-age to 13.1%.

Direct Services
MCH will continue to provide services in OPH for counseling and education sessions to families statewide on healthy eating and physical activity. Referrals to WIC Services for specialized nutrition counseling will continue.

Enabling Services
MCH actively participates in the Southwest Regional USDA committee to address childhood obesity and will develop a tool for diet assessment.

Actively participate with the Family Planning Program and the Title X's Region 6 regional office on a project to address obesity in family planning clinics.

Infrastructure Building Services
MCH will continue to actively participate in the Louisiana Obesity Council and the Southwest

Regional USDA committee. The 5-a-Day program will be promoted through health fairs throughout the state. MCH will continue to actively participate in the Body Wise Program.

State Performance Measure 6: *Percent of women who have had a baby who report physical abuse either during their last pregnancy or in the 12 months prior to becoming pregnant.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	8.0	8	11	10.9	10.8
Annual Indicator	10.1	11.2	11.3	11.3	11.3
Numerator	6614	7037	7061	7061	7061
Denominator	65486.3	62954	62227	62227	62227
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	10.7	10.6	10.7	10.6	10.6

Notes - 2002
Data is from LaPRAMS.

FY 2001 and 2002 estimates are based on 2000 data because more current data is not yet available.

Notes - 2003
The data reported in 2003 are pre-populated with the data from 2002 for this performance measure.

Notes - 2004
The data reported in 2004 are pre-populated with the data from 2002 for this performance measure.

a. Last Year's Accomplishments

Data from the Louisiana Pregnancy Risk Assessment System (LaPRAMS) show that the number of women who reported physical abuse during or in the last 12 months before their recent pregnancy, may be growing. A rate of 9.5 % occurred in 1999. This has been followed by a small increase for the following two years, with 10.1% in 2000, and 11.2% in 2001. In the year 2002, the most current year for which data is available, the rate reported is 11.3%.

Direct Services
The Office of Public Health (OPH) Child Health medical record includes risk factors associated with family violence, including domestic violence. This record, used when the parish health unit serves an infant or child for child health preventive health screening, assesses the family for

exposure to violence.

Enabling Services
The Nurse-Family Partnership (NFP) is operational in all regions of the state, and continues to address domestic violence during pregnancy. Visiting nurses conduct regular assessments for the presence of physical and sexual abuse of the client. If identified, nurses provide support, make appropriate referrals, and provide ongoing case management. A study of the NFP program in Louisiana, completed by Dr. Neil Boris and colleagues at Tulane School of Public Health and Tropical Medicine in 2003, found that 18% of all women enrolled in the study were victims of partner violence, and 21% were perpetrators of violence. However, those in the NFP reported a 9% decrease in victimization, and a 27% decrease in perpetrating violence within 6 months after delivery.

The Louisiana Risk Assessment (LRA), which includes questions about domestic violence, was successfully piloted in 6 Louisiana parishes during pregnancy testing and WIC certification. If the woman had risk factors and would benefit from receiving mental health counseling or other referrals, the RN or SW referred her to the Office of Mental Health (OMH) Early Childhood Supports and Services (ECSS) program or other appropriate referral sources, including referring her to local domestic violence agencies through the OMH -ECSS process.

Population-Based Services
The domestic violence emergency referral/safety cards specific to each region of the state were distributed to all parish health units, and State OPH women's restrooms.
Infrastructure Building Services
The LaPRAMS survey enabled MCH to determine prenatal and postnatal risk behaviors and rates, and to develop appropriately targeted interventions.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Implement risk assessment tools in public health clinics to identify domestic abuse.		X		
2. In prenatal clinics, provide referrals to resources for women facing domestic abuse.		X		
3. Provide pre- and post- natal case management for first time mothers through nurse home visitation services.		X		
4. Distribute domestic violence emergency referral/safety cards to heatlh providers and the public.			X	X
5. Implement LaPRAMS, which identifies prenatal and postnatal risk factors.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Enabling Services
The LRA has been revised and approved for dissemination. Data collection continues to take

place in the pilot parishes, and data collection expansion and updated training is currently taking place. Areas of the state where the OMH ECSS programs are expanding are the Delta, Orleans, and Acadian Programs. The new Best Start Maternal and Child Health Program serves five areas: Lake Charles, New Iberia, Baton Rouge, Ouachita, and Alexandria. Both programs are currently receiving training on the LRA. Identified clients are referred to the Best Start, ECSS, and/or local domestic violence programs for referral. In addition, two contract agencies for the Best Start Program have domestic violence programs under their agency umbrella, and referrals to these programs are facilitated.

In October 2004, the Injury Research and Prevention Program piloted a 3 week long informational display during "Domestic Violence Awareness Month," with brochures and access cards disseminated by local domestic violence agencies. This activity will be extended to several other Regions in the future. During April of 2005, Sexual Assault Awareness Month, all Louisiana Health Units are disseminating sexual assault awareness materials with local resource and 1-800 numbers.

The Nurse-Family Partnership Program, operational in every region of the state, continues to address domestic violence during pregnancy as part of the program design.

The Best Start Program, a new state MCH prevention/intervention program for prenatal and new mothers, also incorporates a screening tool and program approach for domestic violence with every group participant.

All programs serving pregnant women through contract with MCH at the state level also screen, refer, and report domestic violence measures.

Population based services
A new Health Education Coordinator has been hired and is currently updating the domestic violence referral/safety cards for each region of the state. The cards are being translated into Spanish, and dissemination implemented and monitored. In addition, Injury Prevention is disseminating sexual assault awareness materials with local resource and 1-800 numbers in all Louisiana Health Units as part of April of 2005 Sexual Assault Awareness Month.

Infrastructure Building Services
PRAMS data for 2002 was analyzed, with particular attention to trend identification. A MCH Task Force on Domestic Violence is reviewing domestic violence efforts in each region for the MCH population, to best gauge supporting local awareness and intervention efforts through existing contract services and influencing public policy at the state level.

c. Plan for the Coming Year

This Objective will be dropped in the State Performance Plan for the October 2005 to September of 2006 Planning Year. Current efforts are underway to implement and expand a system of data collection using the LRA for referral to ECSS and Best Start programs, surveillance of maternal and child factors at the public health unit level. This will be designated as a performance measure that will replace and include the current Title V Block Grant Measure, State Performance Measure # 6.

State Performance Measure 7: *Percent of women who use substances (alcohol and tobacco) during pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	13.0	12.0	14.5	14	13.5
Annual Indicator	16.1	13.4	12.8	12.8	12.8
Numerator	9824	7690	7655	7655	7655
Denominator	60903	57236	60026	60026	60026
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	13	12.5	12	11.5	11

Notes - 2002

Source:

2002 LaPRAMS (Louisiana Pregnancy Risk Assessment Monitoring System) survey of new mothers.

The numerator is the total # of women included in PRAMS who report that they used cigarettes and /or alcohol during the last 3 months of their most recent pregnancy.

The denominator is the total # of women included in PRAMS minus the # of women who did not answer the question (missing).

Notes - 2003

Source:

2002 LaPRAMS (Louisiana Pregnancy Risk Assessment Monitoring System) survey of new mothers.

The numerator is the total # of women included in PRAMS who report that they used cigarettes and /or alcohol during the last 3 months of their most recent pregnancy.

The denominator is the total # of women included in PRAMS minus the # of women who did not answer the question (missing).

Notes - 2004

Source:

2002 LaPRAMS (Louisiana Pregnancy Risk Assessment Monitoring System) survey of new mothers.

The numerator is the total # of women included in PRAMS who report that they used cigarettes and /or alcohol during the last 3 months of their most recent pregnancy.

The denominator is the total # of women included in PRAMS minus the # of women who did not answer the question (missing).

a. Last Year's Accomplishments

Louisiana Pregnancy Risk Assessment Monitoring System (PRAMS) data for 2002 indicates that 12.8% of all pregnant women reported drinking and/or smoking during the last 3 months of their pregnancy, down from 13.4% in 2001.

Direct Services

MCH continued funding of the Perinatal Enrichment Program (PEP) at Medical Center of Louisiana at New Orleans (MCLNO). PEP provides behavioral health services, such as substance abuse treatment, to drug-affected families. Women in the MCLNO prenatal clinic or entering the perinatal inpatient unit are screened and assessed. Those with moderate or severe problems with drugs and/or alcohol are counseled and encouraged to enroll in PEP. In 2004, 1423 women were screened using the 4P's Plus tool. Urine toxicology screens were performed on all the initial prenatal clients at MCLNO. Of these, 15.6% were positive for THC, 3.6% for cocaine, and 1.3% for opiates. There were 173 perinatal clients enrolled in treatment. Of these, 51.2% also had mental health diagnosis and symptoms. In Region 8, collaboration began with the Office of Addictive Disorders (OAD) in screening and treatment for women with substance abuse.

Enabling Services

The Nurse-Family Partnership (NFP) works to improve women's health behaviors during pregnancy, including prevention of substance use. Nurse visitors provide health education, referrals, case management, and other support to pregnant women. A 2003 report revealed decreased alcohol use and cigarette use in enrolled patients. The NFP program was in 25 parishes of the state.

MCH continued its collaboration with OAD, offering voluntary pregnancy testing to women admitted to OAD rehabilitation and treatment centers. Last year 4.45% women had positive pregnancy tests as compared to 5% in the prior year.

MCH addressed gaps in smoking cessation services for perinatal populations through a contract with the American Cancer Society (ACS). The ACS program, Make Yours a Fresh Start Family (MYFSF), trained 20 facilities which included 19 public providers and 99 private providers, in prenatal smoking cessation counseling. The program screened approximately 5500 pregnant women, and counseled over 1000 pregnant smokers with a 7.1% smoking cessation success rate.

Population-Based Services

The Partners for Healthy Babies (PHB) Campaign continued to promote healthy behaviors in women of reproductive age.

Infrastructure Building Services

The MCH program supported development of screening programs throughout the state. The collaboration with OAD and OMH in Region 8 strengthened. MCH worked with the Family Road Healthy Start in Baton Rouge to evaluate and adopt substance abuse screening. The Louisiana Risk Assessment (LRA) tool has been successfully piloted in 6 regions.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Substance abuse treatment and service coordination through the Perinatal Enrichment Program.	X			

2. Home visitation to low-income mothers and infants.	X	X		
3. Partners for Healthy Babies media and helpline.			X	
4. Intervention through Make Yours A Fresh Start Family smoking cessation Program.		X		
5. Institution of the Perinatal Risk Assessment Tool (LRA).	X	X		
6. Evaluation of the Maternity Program through Quality Assurance (QA) tools.				X
7. Substance abuse screening and referral through the Monroe Pilot Program.	X			
8. Collaboration with Louisiana Public Health Institute, American College of Obstetricians and Gynecologists Louisiana Section, Medicaid, and Planned Parenthood for tobacco prevention activities.	X		X	X
9. Expanded media for tobacco prevention and cessation for pregnant women and families through Louisiana Public Health Institute In-Kind.			X	
10. Regional FIMRs target substance abuse as one of leading risk factors for pre-term labor.				X

b. Current Activities

Direct and Enabling Services
MCH continues to maintain the PEP contract. Clients continued to be actively enrolled and receiving treatment and other services. PEP, through collaboration with other social agencies and programs, provides transportation assistance and referrals to clients for treatment and rehabilitative services.

The LRA is now utilized in 6 regions. The Region 8 -- OAD program screened 769 women for substance abuse, referred 47 for further assessment, and referred 16 for intensive outpatient treatment through April 2005. Referrals are also ongoing for smoking cessation and mental health services. Collaboration with OAD to expand a similar program on a statewide level is occurring. OAD has received Access to Recovery funds, providing a voucher for treatment, with pregnant women one of the target groups.

The voluntary pregnancy testing program in OAD clients continues. The positive pregnancy rate thus far this year is 3.72%. This program allows more rapid diagnosis of pregnancy and referral for prenatal care. Referrals are made to those desiring family planning services in those with negative tests.

Tobacco use screening and cessation in pregnancy is continuing, now in conjunction with Louisiana Public Health Institute (LPHI) and the state Tobacco Control Program. Relationships begun with ACS and MYFSF are being maintained. Louisiana is one of the selected states participating in the Tobacco Cessation Action Learning Lab, partnering with state Medicaid, and Louisiana ACOG, and LPHI.

The NFP program is now providing services, including the prevention of substance abuse in all regions, including 28 parishes.

Population-Based Services
The PHB promotions continue to be funded. LPHI launched a statewide media campaign on smoking cessation, targeted to smoke free families and pregnant women.

Infrastructure Building Services
Substance abuse services were identified as a top priority need within the state, and are being addressed at many levels. The Infant Mortality Reduction Initiative (IMRI) is focusing on factors

contributing to the state's high infant mortality and prematurity rates. Substance use is a significant contribution to these rates, and regional FIMR processes are looking at problems and solutions from the local level. The MCH Maternity Medical Director and Nurse Consultant began "detail visits" to OB Medicaid providers and all birthing hospitals in the regions, providing education and resources.

In May 2005, MCH hosted a forum on Substance Abuse in Pregnancy. Individuals from MCH, OAD and MCLNO participated. From this meeting, the group agreed to proceed with development of a state work plan on substance abuse in pregnancy.

c. Plan for the Coming Year

Objective: Reduce the percent of women who use substances (alcohol and tobacco) during pregnancy to 12.5%.

Direct and Enabling Services
The PEP program at MCLNO will continue to be funded and supported. The Region 8 program in conjunction with OAD will continue. The LRA will expand statewide.

Efforts are continuing through collaboration with LPHI's Tobacco Free Living coordinators in each of the nine regions. The Make Yours a Fresh Start Family provider education program is continuing and expanding through an additional coordinator funded by LPHI. Based in Alexandria, the coordinator will cover the northern part of the state, funded by LPHI. The NFP program will continue to address substance abuse during pregnancy, and provide education, counseling and referrals for women in need of these services in all regions of the state, including 28 parishes.

Population-Based Services
The PHB campaign will continue. LPHI will continue a smoking cessation multimedia campaign statewide.

Infrastructure Building Services
MCH is developing a state work plan on substance abuse in pregnancy in collaboration with OAD. Initial contact has been made to include the Office of Mental Health in this work group. Other state agency stakeholders will be invited to participate. This group will promote use of a statewide screening tool, with brief interventions, and referrals for intensive treatment as needed. Work with OAD will target Access to Recovery funds to help finance this effort.

State involvement with the Action Learning Lab activities will continue and will include strategic planning to include all statewide programs working with tobacco use in women of reproductive age and tobacco impact on preterm birth and families at risk.

The IMRI project is working to develop Regional MCH Forums. These Forums will provide infrastructure at the local level to address substance abuse and its impact on pregnancy. Local strategic planning will evolve. IMRI is planning a free, ongoing CME offering targeted Louisiana obstetrical providers. This offering will include educational materials on incidence, screening and treatment of substance abuse in pregnancy. The MCH Medical Director and Nurse Consultant will continue provider education "detailing visits" to private OB providers with large Medicaid practices and birthing hospitals, reaching all 9 regions.

MCH will meet with Medicaid to promote efforts to enhance quality of care issues. Screening of all pregnant women for substance use at the initial prenatal visit will be recommended.

State Performance Measure 9: *Percent of Central Office and regional epidemiologic positions filled and working on MCH/CSHS data and epidemiologic issues.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	53.0	53.0	90.0	95	95
Annual Indicator	68.4	89.5	95.0	95.0	100.0
Numerator	13	17	19	19	20
Denominator	19	19	20	20	20
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	95	95	95	95	95

a. Last Year's Accomplishments

In 2004, 100% of the MCH epidemiology positions were filled: one CDC senior MCH epidemiologist, 4 MCH program epidemiologists, 3 CSHS, 2 PRAMS, and 9 regional epidemiologists who are partially dedicated to MCH epidemiology. The agency maintains the agreement with the CDC to keep the MCH senior epidemiologist as a CDC MCH Epidemiology assignee.

Infrastructure Building Services
The MCH Epidemiology Assessment & Evaluation (EAE) team supported the regional programs for the analysis of perinatal mortality and the development of evidence-based initiatives such as the Fetal Infant Mortality Review (FIMR). FIMR programs increased to five regions reviewing cases and one in development with a total of 44 cases of infant death reviewed. Markers from Vital Records data were provided in the form of the MCH Data Book. The MCH Data Book was updated to include data from 1990-2002. The EAE group determined priorities based upon analysis of vital records and the Pregnancy Risk Assessment Monitoring System (PRAMS) data, with feedback from MCH programs, regions and the FIMRs.

The linkage of the birth file to other databases was requested and a linkage was obtained to determine Medicaid and non-Medicaid births for the year 2003. The Medicaid-Birth file linkage will be enhanced and its use expanded as a result of the current activities supported by the SSDI grant. The Child Death Review continued reviews of unexpected infant and children deaths. The FIMR program extended the review of the deaths to the fetal period and to all deaths below a year of age.

MCH EAE produced reports on perinatal mortality by administrative region and by some parishes. These reports are updated annually, and presented at conferences and grand rounds 4 times per year. An article was published in the Louisiana Morbidity and Mortality Review on weight gain as a risk factor for birth weight problems. EAE presented research on pregnancy intention, hospital level as a determinant for VLBW deaths, breastfeeding, SIDS, and evidence-

based public health practices, at the Annual MCH EPI Meeting in Tampa, Florida. The MCH Epidemiologist presented infant mortality and FIMR updates to the Perinatal Commission as well as LaPRAMS research results on smoking and weight gain as determinants for LBW and small for gestational age. Specific data for the Healthy Start federal grant applications was provided to the three programs in the state and to a new application for a fourth grant. EAE organized a statewide meeting to address fetal and infant mortality in November 2003 and May 2004, with all the regions represented by public and private sector individuals participating in the Infant Mortality Reduction Initiatives (IMRI). National experts worked with the state participants to apply the concepts to state problems. Participants studied regional and state data and began to establish the top needs and a strategic plan. The reports produced at the meetings were the foundation to the Needs Assessment process.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaboration with regional groups for data requests and analysis.				X
2. Completion of data reports & requests, epidemiological reports, and program evaluation.				X
3. Educational activities and support services for regional and local MCH programs.				X
4. Maintenance of web access to the MCH Data Book and the PRAMS report.				X
5. Provision of timely epidemiological support at all levels.				X
6. Assessment of MCH programs and enterprises for epidemiological issues related to MCH.				X
7. Planning of the statewide conference on perinatal mortality.				X
8. Maintaining the HRSA-CDC ORISE MCH fellow.				X
9.				
10.				

b. Current Activities

Infrastructure Building Services
The MCH Epidemiology program continues a very active inter- and intra-regional collaboration with the existing regional groups working on perinatal mortality and FIMR. All regions are now developed and only Region 1 (New Orleans) is still in the planning process to begin FIMR. Seventy cases of infant death were reviewed by the 6 regional FIMR panels in the current federal fiscal year. The LaPRAMS program finished its seventh year of data collection in November of 2004 and finished its sixth annual PRAMS report. The MCH Epidemiology program continues to develop specific ways to educate program and non-epidemiology staff on MCH Epidemiology, with emphasis on regional development of IMRI teams. The strong linkages with other programs have been enhanced through training and projects with staff representing BRFSS, Injury, and Lead Poisoning Prevention, SIDS, and the State Center for Health Statistics.

An article was published in the Louisiana Morbidity and Mortality Review on strategies for the needs assessment in perinatal health, prenatal HIV prevention counseling and infant mortality in New Orleans. EAE revised and expanded the MCH Data Book and incorporated it into the Office of Public Health Parish Profiles. The Profiles include twenty-five MCH indicators from Healthy People 2010 Objectives. Vital records and PRAMS data were also used for the MCH

Parish Profiles. Data are analyzed and reported at the parish, regional, and state levels. The regional IMRI groups, guided by the MCH EPI group, developed regional reports which were incorporated in the 2005 Title V Needs Assessment. The regional groups worked with regional partners and their reports were presented at the November 2004 MCH meeting with the help of this year's group of nationally recognized researchers and evaluators from the CDC, and the University of California, Los Angeles.

The program continues to provide assessment and technical assistance to all MCH programs and enterprises throughout the state.

c. Plan for the Coming Year

Infrastructure Building Services
Analysis of the available MCH data will continue, and will include the update of the Parish Profiles, the PRAMS Data Book, data requests to support groups throughout the state in grant application processes, and detailed analyses of MCH problems such as domestic violence, breast feeding, SIDS, low birth weight, and others. The MCH planning group, together with the EAE staff, developed an operational plan to address the MCH needs and opportunities identified during the needs assessment process. EAE will strengthen the FIMR activities and the community links so far developed by each regional group. The final goal for the year is to develop strong, data driven MCH infrastructure and leadership in the regions to promote MCH policy, programs, activities and community development.

After successfully meeting the objectives defined several years ago, this performance measure will be discontinued with the expectation that the MCH program will continue to support, recruit and fill Central Office and Regional epidemiological positions, allowing for work to continue on MCH/CSHS data and epidemiologic issues.

State Performance Measure 10: *Percent of licensed day care centers with a health consultant contact.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	40.0	35.0	25.0	37	55
Annual Indicator	27.7	19.0	36.1	52.2	31.0
Numerator	517	398	707	1039	673
Denominator	1869	2100	1957	1989	2170
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	35	37	39	41	43

Notes - 2002

FY 2002 estimates are based on the Child Care Health Consultant monthly report system.

Notes - 2003

FY 2003 data are based on the Child Care Health Consultant monthly report system.

Notes - 2004

FY 2004 data is based on the Child Care Health Consultant monthly report system.

a. Last Year's Accomplishments

In 2004, 31% of licensed day care centers had a health consultant contact... In 2004, an epidemiologist was assigned to monitor and encourage better data collection resulting in a more accurate count of consultant contacts.

Infrastructure Building Services
CCHCs provided 1,770 trainings (over 2,800 hours) to 10,585 child care providers and had 647 technical assistance consultations. The top 3 training topics included medication administration, infectious diseases/infection control, and food safety/preparation. An updated database of all certified Child Care Health Consultants (CCHC) was maintained along with a database of potential candidates desiring to become CCHCs. A videoconference entitled "Health Issues in Child Care" was held in May of 2004 with fifty-six (56) attendees. The videoconference covered questions frequently asked by day care providers and common case scenarios.

CCHCs, local R & R Agencies, parents, and child care providers collaborated to promote the utilization of CCHCs by child care centers statewide. The R&R Agencies linked childcare providers with CCHCs, according to their needs. The R&R Agencies maintained copies of brochures promoting CCHCs and disseminated copies to child care providers and parents on an ongoing basis. The Bureau of Licensing, Department of Social Services (DSS) and Child Care Assistance Program disseminated brochures in license renewal packets for child care centers and registration packets for family day homes.

The CCHC Program maintained a quality improvement system to evaluate the utilization of consultants by childcare centers. CCHCs submitted activity reports monthly for consultation services. The Program Director and Maternal and Child Health (MCH) epidemiologist reviewed and analyzed data from activity reports quarterly. The CCHC Program Director and Quality Improvement Committee received satisfaction surveys from child care providers for satisfaction of CCHC services on an ongoing basis. Over 85% of the respondents said that they were satisfied with the training or technical assistance, 92% found the information from the CCHC to be useful and 95% would contact a CCHC for future assistance.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Facilitate training opportunities and technical assistance in health and safety in child care.				X
2. Plan, initiate and coordinate certification training for Child Care Health Consultants.				X
3. Provide educational materials and training to child care providers on services for CSHCN.				X
4. Serve as a chld care health resource to child care providers and others.			X	X

5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Infrastructure Building Services
There are approximately 2,170 licensed day care centers in the state. There were 673 licensed day care centers (a rate of 31%) with a health consultant contact.

A survey about the interests and activities of CCHCs was collected and analyzed in October 2004. Fifty-two respondents (17-OPH, 28-Private and 7-Affiliation not indicated) revealed a) A variety of topics are used for trainings, b) The most common behavioral problem was "biting", c) There is a need for training on basic indicators of social-emotional problems, and d) 33% reported that they submitted Activity Reports 90-100% of the time.

Although the Transitioning Healthy Child Care America grant ended January 2005, one of the three R&Rs agreed to continue to link child care providers with CCHCs. The participating R&R, the Bureau of Licensing, and DSS distribute CCHC brochures. In April 2005, the CCHC database was placed as a link on the Partners for Healthy Babies website (www.1800251BABY.org), the MCH Program's public information medium.

The Activity Report form was revised in April 2005. The new form captures nationally recommended data, facilitates data collection, and is user-friendly. In conjunction with the Medication Administration Update videoconference in May 2005, the MCH epidemiologist facilitated a review of the Activity Report form and instructions along with frequently asked questions.

The CCHC program promoted ongoing education through a variety of venues. To assist child care providers to meet the 2005 requirements for food safety training, a train-the--trainer video conference for CCHCs was held October 2004 and 2.0 continuing education contact hours were awarded for nurses. There were 110 attendees and Food Safety training compact disks were distributed to all CCHCs. As part of the ongoing CCHC education initiatives, some educational offerings are being opened to persons who have expressed an interest in becoming a certified CCHC. To increase the number of CCHCs in northern Louisiana, a special conference was held there and 26 new consultants were trained. Nurses were granted 16.8 continuing education contact hours. CCHCs were given several tools to disseminate to child care centers including contacts for Regional Medicaid Offices, Covering Kids offices, and other Medicaid enrollment centers.

In May of 2005, the CCHC Program consultant/past-director trained CCHCs in Medication Administration to coincide with updates and revision of the Medication Administration policy. There were 28 in attendance and a videotape of the program is being disseminated upon request. The CCHC Program Director is actively participating on the Early Childhood Comprehensive Systems (ECCS) Strategic Planning Committee, the Infant-Toddler Initiative (Zero-Three Institute), and the Task Force to write Standards for Quality Child Care. The CCHC Quality Improvement Committee meets monthly.

c. Plan for the Coming Year

Objective: Increase the percent of licensed day care centers with a health consultant contact to

37%.

The satisfaction survey form for child care providers is scheduled for revision to elicit more specific information, especially in the areas of their needs and concerns.

The biennial conference to certify new CCHCs and recertify existing CCHCs will be held in the fall of 2005. Along with the standardized basic information for all new CCHCs, the Fall conference will include the following: Behavioral indicators for social-emotional issues, guidelines for developing training modules, and Adult Learning Theories and Practices. These categories were chosen based on the results of the October 2004 survey, the comments on evaluation forms, verbal comments received from CCHCs, and direct observation by the CCHC program director.

To provide accessibility for child care providers and to assure fair and equitable referral opportunities for all CCHCs, the following methods of promoting the CCHC activities will occur: Access to the CCHC database and training calendars via a) Partners for Healthy Babies 1-800 number and website.

The CCHC Program is integrated into the following components of the ECCS Strategic Plans: a) Training in social-emotional development of young children, b) Training on benefits of a medical home, and c) Provision of three hours of health and safety training covered by ECCS funding.

State Performance Measure 11: *Rate of infant deaths due to Sudden Infant Death Syndrome.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	1	1	1	0.9	0.8
Annual Indicator	1.0	0.8	1.0	1.1	1.1
Numerator	68	52	66	70	70
Denominator	67029	67843	64755	64689	64689
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	1.1	1.1	1	1	1

Notes - 2003

Formerly measured under State Performance Measure 8. The objective for the performance measure has been revised to better reflect the overall activities performed related to Sudden Infant Death Syndrome (SIDS).

Notes - 2004

Formerly measured under State Performance Measure 8. The objective for the performance measure has been revised to better reflect the overall activities performed related to Sudden Infant Death Syndrome (SIDS).

a. Last Year's Accomplishments

The Sudden Infant Death Syndrome (SIDS) death rate per 1,000 live births has decreased from 1.3 in 1998 to 1.1 in 2003. The racial disparity between Blacks and Whites has also decreased from 2.3 in 1997 to 1.3 in 2003. Since 1999 there has been a 25% reduction in the SIDS rate for African-American infants. PRAMS data indicate that back sleeping has increased from 32% in 1997 to 46% in 2002. Survey data since initiation of the safe sleep media campaign from 2002 to 2004 has been conducted with Louisiana women ages 18-29 years, with income below $29,000. Data show an increase in the belief that back sleeping is safest (from 42% to 64%). Mothers laying their babies down to sleep on their backs increased (from 34% to 50%). Mothers are more apt to lay a baby down for sleep in a crib (from 71% to 78%) versus an adult bed or other location. Presence of soft bedding such as pillows (from 43% to 23%) and comforters (38% to 18%) in the sleep area has decreased.

Direct and Enabling Services
The SIDS Program coordinated with Children's Bureau to provide counseling for families of SIDS/OID (Other Unexpected Infant Death) victims and ongoing support through a SIDS support group in the New Orleans area. In 2004, Children's Bureau served 17 families with counseling and support. The Office of Public Health (OPH) provided counseling to 15 families in the rest of the state. Children's Bureau has continued a network of parent peer contacts and community health educators to provide additional counseling and resources for SIDS/OID families.

Population-Based Services
A social marketing public information campaign about safe sleep environment was implemented within high-risk areas of the state. Educational materials continued to be distributed statewide to birthing hospitals, healthcare and daycare providers. The SIDS Program continued collaboration with community-based agencies to provide approximately 100 educational sessions. Educational efforts targeted social workers, emergency medical staff, and medical examiners statewide.

Infrastructure Building Services
The MCH Program contracts with Tulane University School of Medicine, Pediatric Pulmonary Section, for the position of SIDS Medical Director. This has continued improved capacity to identify, counsel and follow-up with SIDS families, and improved monitoring of the overall program. A SIDS Program Coordinator works to establish community-based education on SIDS risk reduction in high risk areas. MCH provided SIDS education programs to daycare providers, public health nurses, coroners, law enforcement, social workers and the general public. The Louisiana Child Death Review Panel (CDRP) reviewed all unexpected deaths in children under age 15, including all SIDS deaths. The SIDS Program is utilizing birthing hospital survey data about newborn nursery sleep position policy and hospital discharge counseling to target educational interventions and provided training for newborn nursery staff in hospitals statewide.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Autopsy and death scene investigations are reviewed.				X
2. SIDS related education programs to health professionals, law				

enforcement and the public.			X	X
3. Distribution of educational materials to hospitals, health providers and daycare centers.				X
4. Discharge teaching tool for hospitals developed from birthing hospital survey data distributed to hospitals				X
5. Collaboration with community-based organizations to disseminate SIDS risk reduction message.			X	
6. Distribution of faith community kits to faith based organizations.			X	X
7. Development of a training manual for safe sleep environment promotion for childcare providers.				X
8. Social marketing campaign about safe sleep environment promotion within high-risk areas.			X	
9. Provision of grief counseling for families of SIDS/OID Other Infant Death victims through collaborative agency.		X	X	
10. Coordination of a SIDS support group in the New Orleans metropolitan area.		X	X	

b. Current Activities

Direct and Enabling
The SIDS Program continues to coordinate with Children's Bureau to provide grief counseling for families of SIDS/OID victims and a SIDS support group in the New Orleans area. Children's Bureau has continued a network of parent peer contacts and community health educators to provide additional counseling and resources for families who are victims of SIDS/OID. A pilot research plan is currently being developed to provide safe sleep environment education through WIC clinics.

Population-Based Services
The social marketing public information campaign about safe sleep environment promotion continues within high-risk target population areas through the media, community outreach and medical profession outreach. Current campaign efforts target racial disparities through media placement in African American and low income populations statewide in an effort to increase awareness and influence safe sleeping practices. Current activities include continued development of educational materials, monitoring and tracking of SIDS media placement statewide to assure target audience placement.

Infrastructure Building Services
The SIDS Program continues collaboration with community-based agencies and organizations including family day care/child care providers, senior citizen organizations, and the faith-based community in dissemination of the risk reduction message. Faith community kits continue to be distributed statewide. SIDS program educational efforts continue to target social workers, emergency medical staff, police officers, and medical examiners statewide. A train-the-trainer manual for safe sleep environment promotion for childcare providers was developed. Currently the SIDS Medical Director reviews autopsy and death scene investigations. Death scene investigative report forms were revised and distributed to coroner's offices. In addition, coroner notification protocols of probable SIDS deaths to OPH regional offices have promoted and fostered local relationships with coroner's offices and timely follow-up by OPH regional offices for bereavements services to families. The CDRP continues reviews all unexpected deaths in children under the age of 15, including all SIDS deaths.

The SIDS Program has been working with the MCH Perinatal Mortality Reduction Initiative by provided information and training on SIDS risk reduction to the Fetal Infant Mortality Review (FIMR) medical review and community action teams. The SIDS Program has provided

leadership in development of regional risk reduction activities such as educational and crib giveaway programs.

c. Plan for the Coming Year

Objective: Maintain at 1.1 per 1,000 live births the number of infant deaths due to Sudden Infant Death Syndrome.

Direct and Enabling Services
In addition to providing grief counseling for families of SIDS and ongoing support through the SIDS support group, Children's Bureau plans to continue the network of parent peer contacts and community health educators to provide additional counseling and resources for families who are victims of SIDS/OID (Other Infant Deaths). The OPH will continue to provide bereavement support to SIDS families in the rest of the state. The SIDS Program will continue to pursue development of a pilot plan to provide safe sleep environment education through WIC clinics.

Population-Based Services
The social marketing public information campaign about safe sleep environment promotion will continue to be implemented within high-risk target population areas of the state through the media, community outreach and medical profession outreach. Evaluation of media messages and materials will continue to be performed through formative research. Data on changing parent behaviors will be reviewed for development of new media messages.

Infrastructure Building Services
The SIDS Program will continue interagency collaboration with existing community-based agencies and organizations in promotion of safe sleep environment messages. The SIDS Program plans to develop a comprehensive statewide plan to promote SIDS risk reduction and safe sleep environment and promote regional activities related to safe sleep campaign. The SIDS Program will continue to provide technical assistance for development of policy and/or regulatory standards related to safe sleep environment in licensed childcare. The SIDS Program plans to continue provision of training for licensed child care and family day home providers related to safe sleep environment. Training will be provided to health care professionals and providers including physicians, nurses and OPH Program staff such as Early Steps, NFP, Best Start, social workers and PHU nurses.

Autopsy and death scene investigations will continue to be reviewed by the SIDS Medical Director. The SIDS Program plans to provide death scene investigation training for coroner investigators and produce an investigation form that can be downloaded from the Internet for coroner's investigators to promote efficient submittal of investigative forms to OPH. Child Death Review Panel will continue reviewing SIDS deaths as well. Special reports on infant mortality will continue to be provided to the State Commission on Perinatal Care and Infant Mortality, SIDS Steering Committee, and other interested groups.

E. OTHER PROGRAM ACTIVITIES

Infrastructure Building Services

Surveillance
MCH, in conjunction with the Genetics and Lead Section in the Office of Public Health (OPH), has been the recipient of a CDC lead surveillance and prevention grant to establish a statewide population based childhood lead surveillance system. This Program utilizes data from the surveillance system to develop initiatives in those areas of the State with the highest prevalence of childhood lead poisoning. Initiatives include outreach, public and professional education, and developing partnerships with

community agencies and organizations to decrease childhood lead poisoning. A Plan For the Elimination of Childhood Lead Poisoning has been developed and is in the process of implementation.

Other information systems to monitor health include development of a statewide immunization registry (LINKS), ongoing pediatric nutrition surveillance of children through the Pediatric Nutrition Surveillance System (PDNSS), and a State Child Death Review Panel, which also coordinates and supports Local Child Death Review Panels. The CSHS program has implemented recent legislation for a Birth Defects Monitoring Network for surveillance and referral to services. The system began surveillance activities in January 2005.

Coordination/Policy Development
The MCH Program has participated in the development and implementation of the Early Childhood Supports and Services Program. This 6 parish pilot program is an initiative of the Office of Mental Health that establishes a local system for referral of children from birth to 5 years who are at risk for the development of poor mental health, emotional, or developmental outcomes. Children who are screened and found to be at risk for poor outcomes are referred to a local multi-agency coordinating group who develop a plan to provide the supports and services that are needed to improve the outcomes for the individual children and their families. A system for screening and referral of infants in the pilot parishes through the local public health units has been implemented. In addition, a pilot collaboration of the ECSS and EarlySteps Regional Advisory groups has been initiated to reduce duplication in services to children birth to age 3. This program is planned to be expanded to an additional 8 parishes in 2005.

Through the federally funded State Systems Development Initiative for Early Childhood Comprehensive Services Systems (ECCS), the MCH Program has worked with the Louisiana Children's Cabinet and its Advisory Group to establish a framework for the implementation of a system of comprehensive services for the early childhood period. A Needs Assessment focusing on the areas of a Medical Home, Mental Health/Socio-emotional Services, Child Care and Early Education, Parent Education, and Family Support Services had been completed and a Strategic Plan is being completed with plans to begin implementation of the plan in the next year.

Toll Free Hotline
The Maternal and Child Health Toll-free 1-800 number, entitled Partners for Healthy Babies (1-800-251-BABY), provides confidential information for women who call seeking referrals for prenatal care and pregnancy testing. Also provided is information regarding primary and preventive services for children, including services for children with special health care needs, as well as referrals for immunizations and information about LaCHIP and Medicaid. The Louisiana OPH Shots for Tots initiative, in coordination with the Partners for Healthy Babies Project, utilizes the helpline number. Family Planning referrals are also available to callers. The helpline provides referrals to the public and private physicians who provide Title V and XIX services. The Partners For Healthy Babies services are communicated to the public through television, radio, billboards and bus placard advertising. In addition, promotional/incentive campaigns, newspaper articles and public relations meetings with community leaders are also utilized to make the public aware of this information and referral service.

Children's Special Health Services has completed the redesign and transfer of the Part C of IDEA system in Louisiana to the Office of Public Health. In addition to the involvement of parents and stakeholders in redesign activities, other offices in OPH as well as DHH continue to be involved in the Part C Program named Early Steps. EarlySteps staff have participated in the ECCS grant activities. The number of enrolled children in Part C has increased by 43% in the first two years of implementation. Due to the tremendous increase in infants and toddlers served, budget overruns occurred. The program is in the process of a restructuring to make the most efficient use of limited funds.

F. TECHNICAL ASSISTANCE

Technical Assistance needs are described in From 15. Please see this form for a complete list of anticipated needs.

V. BUDGET NARRATIVE

A. EXPENDITURES

Successful efforts to redirect funding began soon after the Office of Public Health downsizing in 2001. A plan was developed based on the 2000 MCH Needs Assessment to establish new infrastructure for MCH activities through contract agencies. Since 2001, MCH staff has been establishing partnerships in each region to build MCH infrastructure and services. The success of these efforts is reflected in the increase in expenditures in fiscal years 2002 through 2004. Expenditures have increased to pre-2001 levels.

On Form 3, FY 2004 budgeted figures for Unobligated Balance was zero and the expended amount was $2,017,772. This was due to under-collection in the Program Income category. Program Income was projected to be much higher than was actually collected. This was due to delays in obtaining federal approval from the Centers for Medicare and Medicaid for the expansion of the Nurse Family Partnership Program as a Medicaid covered service in 3 additional regions of the state. Approval was given in the following fiscal year and will be reflected in the FY 2005 expenditure report. This delay in obtaining approval and collections resulted in this amount of unobligated MCH funds expended during FY 2004.

On Form 4, FY 2004 budgeted amount for Pregnant Women was set too low compared to expenditures. Prenatal care and Nurse Family Partnership contracts that began in FY 2003 became fully operational in FY 2004, thus increasing the expended amount. The FY 2004 budgeted amount for children 1 to 22 years was set too high, and the expended amount was consistent with prior fiscal years. The FY 2004 budgeted amount for the Other category was set too low compared to the expended amount, which is consistent with the amount budgeted for Family Planning services. The FY 2004 expended amount for Administration was lower than the budgeted amount due to the overall expenditures being lower than the budgeted amount.

On Form 5, in FY 2004, expenditures on Direct Services decreased while expenditures on Enabling Services increased. This was due to the increase in Nurse Family Partnership expenditures resulting from program expansion and the continuing decrease in direct maternity and child health services delivered by the Parish Health Units. Expenditures on Infrastructure Building services were less than the budgeted amount due to loss of the reporting mechanism that previously extracted Regional Office of Public Health Infrastructure expenditures from the Direct Services category.

B. BUDGET

The following services and projects are funded by the MCH Block Grant, Title XIX, patient fees, insurance reimbursements, and local and state funds:
1. Maternity/Family Planning
2. Child Health Preventive/primary services for children birth to 21.
a. Child Health
b. Communicative Disorders Preventive
c. Immunization
3. Children's Special Health Services
a. Children's Special Health Services

The MCH Block Grant supports the state central and regional administrative consultative staff who sets standards of care, develop policies and procedures, train field staff, and provide quality assurance. The amount budgeted for the Central Office of Public Health MCH staff represents the cost of building the capacity of the state to develop community based systems of care. This amount is presented for each of the program components. In addition, other core public health services, direct personal health services, enabling services, and population-based services are included in the following budget. Please see the attachment, Tables 1, 2 and 3, for each type of service for each program component, including the amount budgeted for the service separated into the federal

contributions.

The service areas (reporting categories), which relate to preventive and primary care services for children, are provided in Table 2 (see attachment). The amount of funds budgeted in these service areas for fiscal year 2006 exceeds 30 percent of the total MCH Block grant. Thus, there is no need to redirect the MCH program in order to comply with this requirement. Compliance verification based on the actual funds disbursed will be performed and documented by the Fiscal Office at the end of each state fiscal year.

A minimum of 30 percent of federal funds received for use in subsequent fiscal years and the associated match will be budgeted for use in programs that provide services for children with special health care needs. The amounts listed on Table 3 (see attachment) will be budgeted for fiscal year 2006. Compliance verification based on the actual funds disbursed will be performed and documented by the Fiscal Office at the end of each state fiscal year.

Sources of State Match and Overmatch Funds
Funds for Maternal and Child Health Services will be obtained from state general funds.

Program Income
Program income comes from Title XIX funds, fees, and third party payers. Table 4 (see attachment) presents the distribution of this income by program component.

Budgeting for Cross cutting Programs
The Office of Public Health is able to associate all expenditures including each staff person's work activity with the correct funding source by a system using reporting categories. The Office of Public Health budget is divided into many service areas, each identified by a reporting category. Most Office of Public Health employees utilize this Reporting Category system to allocate their time and other expenditures to a particular project or service area. This system allows staff working across many programs to allocate their time and other expenditures appropriately.

Use of Overmatch Funds
There is no overmatch that is under the control of the State Title V Agency that is used to match other federal programs.

Fees
Maternal and child health patients receiving services at parish health units and are above 100% of the poverty level are charged $5 per clinic visit and $5 for pharmacy services. Individuals receiving only immunizations, and that are above 100% of the poverty level, are charged $10.00. Family planning patients are charged fees according to a sliding fee scale.

Administrative Costs
Administrative costs are the portion of costs incurred by the following service units that are directly allocated to Maternal and Child Health Services Programs in accordance with Sections 3 and 5 (where applicable) of the Department of Health and Hospitals Cost Allocation Plan:
Office of Assistant Secretary-Management Information Systems (MIS)
- Human Resources Section - Policy, Planning and Evaluation
Administrative Services Operations and Support Services
Statewide Costs (Purchasing, Civil Service, Treasurer, Fiscal, etc.)

Collectively these are referred to as Executive Overhead costs. Compliance verification of the 10 percent administrative restriction will be performed and documented by the Fiscal Office at the end of each state fiscal year. The estimated administrative costs for the total budget are $4,376,520 for fiscal year 2005-2006. The estimated Federal share is $1,420,352 or 10.0% of the federal funds requested.

Administrative Cost Limit - The administrative budget represents no more than 10.0% of the federal funds requested.

"30 30" Minimum Funding Requirements - The preventive and primary care services for children represent 35.1% of the Block Grant and Children with Special Health Care Needs represent 31.8% of the Block Grant budget. The definitions and descriptions of the services for these project components can be found in the program narratives.

Maintenance of State Effort - The State Office of Public Health intends to pursue and expects to obtain state general funds for Maternal and Child Health Services that equals or exceeds the level of such funds provided during state fiscal year 1989. Compliance verification will be performed and documented by the Fiscal Office at the end of each state fiscal year. The state support in state fiscal year 1989 was $6,207,276.

Allocation for Activity Conducted to Continue Consolidated Health Programs
The following federally funded programs were consolidated by the Maternal and Child Health Block Grant in fiscal year 1981 1982 in Louisiana:
1. Maternal and Child Health Program;
2. Crippled Children's Services Program (in Louisiana called Children's Special Health Services);
3. Supplemental Security Income/Disabled Children's Program
4. Lead Based Paint Poisoning Prevention Program (previously funded only in City of New Orleans in Louisiana);
5. Genetic Diseases Program (incorporated previous funds for sickle cell disease at Flint Goodridge Hospital in N.O.);
6. Sudden Infant Death Syndrome (SIDS) not funded in Louisiana; and
7. Adolescent Pregnancy Program not funded in Louisiana.

The following state funded programs in effect in Louisiana at the time of Block Grant Legislation in 1981 were also incorporated into the Maternal and Child Health Block Grant:
1. Genetic Diseases Program statewide screening for certain inherited disorders such as PKU, hypothyroidism, and sickle cell anemia.
2. Sudden Infant Death Syndrome (SIDS) Program follow up and counseling of affected families statewide.

Special Projects In Effect Before August 31, 1981
1. Maternal and Infant Care Project discontinued;
2. Children and Youth Project discontinued;
3. Family Planning absorbed into general Family Planning Program; Title V funding for Family Planning Program is budgeted at $1,925,000;
4. Dental Health For Children reduced services current funding for Dental Services for Children's Special Health Services New Orleans District Office;
5. Neonatal Intensive Care absorbed by Louisiana State University Medical Center in Shreveport.

VI. Reporting Forms-General Information

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note

Please refer to Section IX of the Guidance.

X. Appendices and State Supporting Documents

A. Needs Assessment

Please refer to Section II attachments, if provided.

B. All Reporting Forms

Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents

Please refer to Section III, C "Organizational Structure".

D. Annual Report Data

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.